



INSTRUCTIONS

- Please follow directions carefully and answer all questions. Health Services reserves the right to require a physical exam whenever indicated.
- Please print neatly.
- Please scan and upload your COMPLETED Form (no blank pages please) to <https://emu.medicatconnect.com/>
- **If unable to upload electronically, please return COMPLETED form including immunization record to EMU Health Services by mailing or emailing by August 1st for fall registration and December 5th for spring registration (or upon admission to graduate/seminary program). Failure to comply will result with a hold in your registration process for the following semester.**

Admitted to: (Please Circle One) CJP, MAC, Seminary, MBA, M.Ed., MA BioMedicine

Name: _____ **EMU ID#:** _____
 LAST/Family FIRST/Given SECOND/Additional

Local mailing address: _____, _____, _____
 Number & Street/ Route & Box City State Zip Code

Home Phone: (____)____-____ **Cell phone:** (____)____-____ **Age:** ____ **Date of Birth(mm/dd/yyyy):** _____

Birth Country: _____ ☐ Male ☐ Female **SS#:** _____-____-____

Emergency contact: _____ **Relationship:** _____ **Phone:** (____)____-____

Health Care Provider: _____ **Phone:** (____)____-____

Were you enrolled at EMU prior to this admission: ☐ yes ☐ no

Name during prior enrollment: _____ **Departure date/year of prior enrollment:** _____

HEALTH INSURANCE INFORMATION

- Please complete page 3 of this form and upload a copy of the front and back of your insurance card.

Personal/Family History:

Have you or any of your family ever had any of the following illnesses? If yes, please give relationship, i.e. self, mother, father, uncle, etc.

Asthma	Cancer – type:
Depression/anxiety/other	Diabetes
Heart disease	High blood pressure
Kidney disease	Tuberculosis
Any chronic illness not mentioned	Sudden death before age 50

Allergies (drug, food, etc.) _____

Hospitalizations/Surgeries (reasons & dates) _____

Current medications taken regularly _____

I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at EMU. It is my responsibility to notify EMU Health Services of health/insurance changes while enrolled. By signing below I authorize release of pertinent medical information and future medical consultations with relevant EMU Departments knowing that all medical information will be kept confidential.

Signature of student: _____ **Date:** _____

EASTERN MENNONITE UNIVERSITY IMMUNIZATION RECORD

Name: _____

Last Name

First Name

EMU ID number: _____

Date of Birth (mm/dd/yyyy): ____/____/____

- You can request immunizations from:
 Health care provider Your local health dept. Undergrad. College/Univ. High School/Central Office
- Please have a health care provider complete this form and sign it at the bottom, **OR** have the health care provider fax your immunization records. **NOTE: If immunization records are not available, blood titer reports are sufficient.**

****Required**** **TB screening at a U.S. facility is required.**

TB Screening date – **Must be within one year of current enrollment:** ____/____/____ RESULT: Positive / Negative

IF POSITIVE, complete a, b, and/or c below.

a. PPD (Mantoux) Date Given ____/____/____ Date Read ____/____/____ Result ____ mm induration (horizontal diameter)

b. IGRA blood test results (T-Spot, Quantiferon Gold) -- Positive / Negative -- Date ____/____/____

c. Chest x-ray - if positive IGRA blood test or ppd (attach x-ray report)

☐ INH Prophylaxis: Dates: From ____/____/____ To ____/____/____ OR ☐ Sign waiver for INH Therapy

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE OF TITER&RESULT (or disease)
DPT series					
Hepatitis B series (or sign Waiver)					
MMR – measles, mumps, rubella (not required if born before 1957)					
Meningococcal – one must be given at age 16 or older (or sign Waiver)					
Polio series OPV/IPV (circle one)					
TDAP / TD (within 10 yrs.)					
Varicella - chicken pox (or year of disease; not required if born before 1980)					

Health Care Provider: _____ Date _____

Signature/Title

Phone Number

Health Care Provider: _____

PRINT NAME

Fax Number

Meningitis Waiver

I have read the meningococcal disease and immunization information from the Virginia Department of Health website <http://www.vdh.state.va.us/Epidemiology/factsheets/Meningococcal.htm> and the CDC vaccine information sheet at: <http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf> . I have chosen not to be vaccinated.

Signature of Student _____ Printed Name _____ Date _____

Hepatitis B Waiver

I have read the hepatitis B disease and immunization information from the Virginia Department of Health website http://www.vdh.state.va.us/Epidemiology/factsheets/Hepatitis_B.htm and the CDC vaccine information sheet at: <http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-hep-b.pdf> . I have chosen not to be vaccinated.

Signature of Student _____ Printed Name _____ Date _____

Eastern Mennonite University HEALTH INSURANCE INFORMATION

Student's Name: _____ Date of Birth: _____ EMU ID: _____

- **ATTACH** a legible copy of the front & back of your current insurance card (if covered on multiple plans, please indicate which insurance is **PRIMARY** and which is **SECONDARY** coverage).
- It is recommended for students to keep a copy of their insurance card with them at all times.
- Check with your insurance provider to see what kind of health care coverage you have while attending Eastern Mennonite University (i.e. out of state, out of network, etc.).
- **Provide updated information** to EMU Health Services if you have insurance coverage changes while enrolled at EMU to prevent delays/denials with claims.
- EMU Health Services does not accept **Medicare**.

Please check all that apply to you currently:

_____ I have **enrolled** for EMU Health insurance coverage.

_____ I have **private** health insurance in my/parent's name, i.e. Aetna, Blue Cross/Blue Shield, Cigna, Kaiser, Optima, United, etc.

Name of Insurance Company: _____

_____ I have **Medicaid** coverage. If yes: _____ VA Medicaid _____ Out-of-state Medicaid

_____ I do not have health insurance and expect to pay the "Self-pay" charge at the time of service.

Patient Insurance Authorization:

I hereby authorize EMU to furnish information to insurance carriers concerning my illness, condition, and treatment, and I hereby irrevocably assign to EMU Health Services all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges that may be charged to my student health account.

Signature of Patient

Date

Name of Policyholder/Subscriber

Policyholder/Subscriber's Birthdate