# EMU Health Information Form

**FOR PART-TIME STUDENTS**

EMU Health Services, 1200 Park Rd., H'burg, VA 22802
Phone: (540) 432-4308

**Upload Completed Form at https://emu.medicatconnect.com/**

**Please complete this form if you wish to access Health Services as a Part-time student:**

**INSTRUCTIONS:**

- **Student** completes and signs Pages 1, 2 & 3 **Please print legibly.**
- **Parent** signs page 3 also if student is a dependent on Parent's insurance.
- **Forms are due by June 15th for fall registration and December 5th for spring registration.**
- **UPLOAD your COMPLETED Health Information form at https://emu.medicatconnect.com/ (Please do not upload BLANK or INCOMPLETE pages.)**
- **Please remember to upload a copy of your insurance card in addition to completing page 3.**

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

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

**Home Phone:** (_____)_____ - _____ **Student's Cell phone:** (_____)_____ - _____

**Preferred Pronoun(s):**_____ **SS#:** _____-_____-_____ **Age:** _____ **Date of Birth:** _____/_____/_____
MM DD YEAR

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

**Were you enrolled at EMU prior to this admission:** ☐ yes ☐ no **Name during prior enrollment:** _____

## HEALTH INSURANCE INFORMATION – *Complete page 3 of this form and include a copy of your insurance card – front and back- and upload with your COMPLETED Health Information form*

****EMU Health Services bills insurance.**

## Family History:

Have any of your family or blood relatives ever had any of the following illnesses? If yes, please give relationship, i.e. 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 |

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:** _____

# PERSONAL HEALTH HISTORY – to be **completed by student prior to physical**

**Student Name:**_____

**Circle** any of the following you have had:

| | | |
|---|---|---|
| Abnormal bleeding/bruising | Eating disorder | Kidney disorder |
| Acne | Epilepsy, Seizure | Menstrual problems (cramping, missed periods) |
| ADD/ADHD | Eye problems, uncorrected | Rheumatic Fever |
| Allergies | Head injury | Scoliosis |
| Anemia | Headaches, migraine | Seizures |
| Anxiety | Hearing impairment | Sickle-cell disease/trait |
| Arthritis | Heart disease/arrhythmias | Single organs (kidney, eye, etc.) |
| Asthma, emphysema | Hernia | Skin problems (recurrent infections, rash, itching) |
| Broken bones/stress fracture | High blood pressure | Substance use – alcohol, tobacco, marijuana |
| Cancer – type: _____ | HIV/AIDS | Undescended testicle |
| Depression | Joint Injury – site:_____ | Urinary tract infection |
| Diabetes | | |

Typical Habits: **Exercise** – YES NO How many times a week? ____ **Sleep** – how many hrs. per night? ____

**Caffeine** – how many cups per day? _____

| | | YES | NO |
|---|---|---|---|
| 1. | Do you have any chronic health problems which require regular treatment or may require treatment? | □ | □ |
| 2. | Do you have any disability: physical, emotional, learning, etc.? | □ | □ |
| 3. | Have you ever received professional counseling for any psychological problem? | □ | □ |
| 4. | Is there any way we can be of assistance to you because of any limitation or health problem you may have? | □ | □ |
| 5. | Have you ever passed out during or after exercise? | □ | □ |
| 6. | Have you ever been dizzy during or after exercise? | □ | □ |
| 7. | Have you ever had chest pain during or after exercise? | □ | □ |
| 8. | Do you tire more quickly than your friends during exercise? | □ | □ |
| 9. | Have you ever had high blood pressure? | □ | □ |
| 10. | Have you ever been told that you have a heart murmur? | □ | □ |
| 11. | Have you ever had racing of your heart or skipped heartbeats? | □ | □ |
| 12. | Do you use any special equipment daily or with sports (wheelchair, cane, braces) | □ | □ |
| 13. | Have you ever had heat stroke or heat exhaustion? | □ | □ |
| 14. | Have you ever had a concussion? If yes, how many? ____ | □ | □ |

Number of times you lost consciousness _____ Dates of concussions _____

If you answered **YES** to any of the above questions, give significant explanation and dates for each.

_____

Hospitalizations/Surgeries/Injuries – sprains/fractures: (list reasons & dates):_____

List any illness, injury or chronic health problem other than those already noted:

_____

Drug allergies: _____ Reaction: _____ Treatment required: _____

Food allergies: _____ Reaction: _____ Treatment required: _____

Insect/bee stings: _____ Reaction: _____ Treatment required: _____

Current medications taken regularly (include prescription, over-the-counter, and supplements):

_____

**I do not know of any existing physical conditions or additional health reasons that would preclude my participation in collegiate activities and sports. I certify that the answers to the above questions are true and accurate.**

**Student Signature:** _____

# EMU HEALTH INSURANCE INFORMATION

[*To be completed by student and/or parent/guardian*]

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.

PARENTS/Guardians: PLEASE NOTIFY YOUR HEALTH INSURANCE COMPANY that your son/daughter will be a part-time student at Eastern Mennonite University in Harrisonburg, VA- BEFORE arriving on campus. This will confirm whether your son/daughter will be covered while at EMU.

**Name of Insurance Company**: _____

_____ I have **Medicaid** coverage. If yes: _____ VA Medicaid _____Out-of-state Medicaid
NOTE: **Virginia Medicaid is the only Medicaid accepted by EMU Health Services.**

_____ 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

_____ _____
Signature of Parent/Guardian (IF STUDENT IS UNDER 18) Date