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:** (_____)_____ - _____

☐ Male ☐ Female **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: _____

Eastern Mennonite University 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 full 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

_____ 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