



EMU Health Information Form

EMU Health Services, 1200 Park Rd., H'burg, VA 22802

Phone: (540) 432-4308

Upload Completed Form at <https://emu.medicatconnect.com/>

INSTRUCTIONS - Please complete and upload the forms by July 1 (for Fall enrollment) or December 5 (for Spring enrollment)

- Student completes and signs Pages 1, 2 and 4. **Please print legibly.**
- Health Care Provider completes and signs Pages 3 [Pg 3 & 5 for Athletes]
- Fall enrollment - physical performed within the past year; Performed AFTER May 15 for Athletes
- Spring enrollment - physical performed within the past year; Performed AFTER Nov. 15 for Athletes

UPLOAD your COMPLETED Health Information form at <https://emu.medicatconnect.com/>

(Please do not upload BLANK or INCOMPLETE pages.)

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: (____)____ - _____

Pronoun: _____ 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 4 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: _____

Student Name:_____

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		

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

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

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):

Student Signature: _____

EMU - PHYSICAL & IMMUNIZATION RECORD

****Please have a health care provider complete this form and sign it at the bottom.**

Name: _____

Last Name

First Name

EMU ID number: _____ Age: _____ Date of Birth: ____/____/____ Pronoun(s): _____ HT: _____ WT: _____
Month – Day – Year

Standing BP: _____ Sitting BP: _____ Pulse: _____

Glasses - YES NO Contacts - YES NO Eye protection - YES NO Vision: R _____ L _____ Pupils: R _____ L _____

Mark each item WNL (Within Normal Limits) or A (Abnormal)		*If any Abnormal, explain in comments.	
HEENT		COMMENTS	
Fundoscopy		Dental	
Ears		Nodes	
Mouth		Lungs/chest	
Throat		Thyroid	
Cardiac			
Including precordial auscultation (supine & standing) and femoral artery pulses.			
Abdomen		Neuro	
Genitalia		Depression/Anxiety	
Hernia		Other psych.disorders	
Skin			
Musculoskeletal			
Neck		Hip	
Thoracic/Lumbar		Quad/Hamstring	
Shoulder		Knee	
Elbow		Ankle/Feet	
Wrist/Hands		Gait	

TB SCREENING at a U.S. facility is **REQUIRED**

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

IF TB Screening is 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
Hepatitis A (2 doses)					
Hep AB Twinrix (3 doses)					
Hepatitis B					
MMR – measles, mumps, rubella (if born after 1956)					
Meningococcal (MenACWY)– one must be given at age 16 or older					
Polio-last booster					
TDAP (within 10 yrs.)					
Varicella (2 vacc) or yr. of disease	Vaccine #1:	Vaccine #2:	Date of disease:		

Meningitis Waiver - I have read the meningococcal immunization information from 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 _____

If you wish to sign a waiver for any other vaccines please go to <https://emu.edu/studentlife/health/docs/vaccine-waiver.pdf> -and follow the instructions.

Health Care Provider: _____ Date _____

Signature/Title

Phone Number

Health Care Provider: _____

PRINT NAME

Address

Fax Number

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 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
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



Physician Clearance to Participate in NCAA Intercollegiate Athletics

MEDICAL DOCUMENT FOR: _____ Sport: _____
(Athlete's full name)

BANNED MEDICATION STATEMENT:

The NCAA list of [banned drug classes](#) (NCAA Division I Bylaw 18.4.1.4.6 and NCAA Division II and III Bylaw 31.2.3.1) is composed of substances that are generally purported to be performance enhancing and/or potentially harmful to the health and safety of the student-athlete.

The NCAA recognizes that some banned substances are used for legitimate medical purposes. Accordingly, the NCAA allows exception to be made for those student-athletes with a documented medical history demonstrating the need for treatment with certain banned medications. Medical exceptions may be granted for substances in the following banned drug classes: anabolic agents*, stimulants, beta blockers, diuretics and masking agents, hormone and metabolic modulators*, beta-2 agonists, peptide hormones*, growth factors or related substances and mimetics*, and narcotics (see subpart 2 below). Per NCAA Division I Bylaw 18.4.1.4.8 and Division II and III Bylaw 31.2.3.2, a medical exception is not permitted for a substance in the class of cannabinoids.

**Note: The use of an anabolic agent, hormone and metabolic modulator, peptide hormone, growth factors, related substances and mimetics must be approved by the NCAA before the student-athlete is allowed to participate in competition while taking these medications.*

****A [medical exemption form](#) must be completed for those individuals taking medications to treat ADD/ADHD.**

SICKLE CELL STATEMENT:

The NCAA has asked member institutions to educate all athletes on sickle cell trait. Sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin (red blood cell) and one for normal hemoglobin. Sickle cell trait is a lifelong condition that will not change over time. The danger of this condition occurs when an athlete with sickle cell trait exercises intensely. Some athletes have experienced significant physical distress, collapse and some have even died. To be in compliance with NCAA requirements you must identify your sickle cell trait status. The test for sickle cell trait may have been conducted at your birth. More information on sickle cell trait can be obtained from the NCAA at <https://www.ncaa.org/sports/2016/7/27/sickle-cell-trait.aspx>. Please be aware that having this condition will not exclude your participation but will require that exercise precautions be put in place. Failure to comply with this requirement will delay your clearance to participate.

**** YOU MUST PROVIDE A COPY OF THE LAB RESULTS TO EMU ATHLETIC TRAINING****

PHYSICIAN CLEARANCE:

I have examined the above named student and completed the pre-participation evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined below. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete.

- ☐ A. Cleared for all sports without restriction
☐ B. Cleared without restriction with recommendation after completing evaluation/rehabilitation for: _____
☐ C. Not cleared for: _____ Pending further evaluation _____ For Any Sports _____ For Certain Sports

Reason: _____

Signature of Examiner: _____ (MD, DO, PA, NP) Date: _____

Printed Name of Examiner: _____

Address: _____
 Street/Route City State Zip Code

Phone: _____ Fax: _____