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/

FORMS ARE DUE by July 1st for fall registration and December 5th for spring registration.
Failure to comply will result with a HOLD in your registration process.

INSTRUCTIONS

- **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:** _____

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 - 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**			**COMMENTS**
Fundoscopic			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					
Covid19Vaccine(s) Include name ie: Pfizer; Moderna; J&J			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)

ADHD MEDICATION STATEMENT:
The NCAA requires documentation for stimulant medication commonly prescribed for Attention Deficit Hyperactivity Disorder (ADHD). Many medications used to treat this disorder are among those substances banned by the NCAA. Institutions must present documentation that these medications have been prescribed by a physician and also have been supported by a clinical assessment for education or health reasons. See (www.ncaa.org) Banned Drugs and Medical Exceptions Policy for further explanation. Please provide the following information if you are taking any medication for ADHD.

Prescribing Physician: _____

Physician's Address: _____

Phone and Fax number: _____

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 www.NCAA.org/health-safety. 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 ****

Date tested: _____

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: _____