

Personal and Emergency Information:

Student's Name _____ SSN _____ Male Female
 Address _____ Phone _____
 City/State/Zip _____ Date of Birth _____
 Citizenship _____ Date of Enrollment: Year _____ Semester _____
 Person to notify in an emergency _____
 Relationship _____ Work Phone _____
 Home Phone _____ Mobile Phone _____

Insurance Information:

Company _____ Phone _____
 Policy Number _____ Group Number _____
 Primary Cardholders Name _____ Primary Cardholder's ID Number _____
 Primary Care Physician's Name _____ Phone _____
 I prefer the following Hospital/Clinic to be utilized if necessary: Scott and White King's Daughters Hillcrest

Immunization Information:

Meningococcal Vaccine: *Read the following statement.*

Although the University of Mary Hardin-Baylor does not require students to be immunized against bacterial meningitis, we do require students and/or parents to make an informed decision about whether or not to be vaccinated.

Bacterial meningitis is a serious, potentially deadly disease that can progress rapidly. The bacteria causing this disease is transmitted by exposure to saliva by sharing drinks, eating utensils, cigarettes, or other contact with respiratory or throat secretions, such as kissing or living in close quarters. The disease causes swelling of the membranes that surround the brain and spinal column and may infect the blood. The disease strikes about 3,000 Americans each year, including 100-125 on college campuses, leading to 5-15 deaths among college students each year. There is a treatment, but those who survive often develop severe health problems or disabilities.

A vaccine exists that protects individuals against 4 of the 5 most common bacterial types that cause 70% of cases in the U.S. College freshmen living in dormitories are among one of the highest risk groups. The American College Health Association and the Centers for Disease Control and Prevention strongly recommend the vaccine to these individuals. The University of Mary Hardin-Baylor recommends that all college students living in dormitories and college students 25 years old and younger seriously consider receiving the vaccine. For more information about bacterial meningitis or the vaccine, contact your own health care provider or contact the following web sites: www.acha.org and www.cdc.gov.

MUST indicate a response:

- I have already been immunized against bacterial meningitis. Date of vaccination ____/____/____
- I have considered my personal risk for the disease and have chosen not to be vaccinated.
- I understand the risk involved, but am still in the process of deciding whether or not to be vaccinated.

Tuberculosis: *Must be within last year if you have been outside the United States. Chest x-ray required if skin test results are positive.*

Skin Test Date administered ____/____/____ Date read ____/____/____ Result: Pos. / Neg.
 Chest x-ray Date read ____/____/____ Result: Pos. / Neg.

Tetanus Diphtheria: *Must be within last 10 years.* Date administered ____/____/____

Measles, Mumps and Rubella (German Measles): *Suggested for all students born on or after January 1, 1957, two doses are recommended, one dose is considered unreliable.*

MMR Dose #1: Date ____/____/____ MMR Dose #2: Date ____/____/____ **OR** Measles: Date ____/____/____

Varivax (Chickenpox Vaccine): *(If given) Two doses required if given after age 13.*

Dose #1 Date ____/____/____ Dose#2 Date ____/____/____ **OR** Disease: Date ____/____/____

Hepatitis B *(If given)* Dose#1 Date ____/____/____ Dose#2 Date ____/____/____ Dose#3 Date ____/____/____

Hepatitis A *(If given)* Dose#1 Date ____/____/____ Dose#2 Date ____/____/____

Validated by: _____ (MD, RN, LVN, or PA)

Place health care provider address or stamp in space at right.

Immunization dates may be authenticated at UMHB by providing a photocopy of TB skin test results AND a photocopy of original immunization record, public high school immunization record, or proof of active military service. If copies are submitted, **check carefully to be sure each date meets specific requirements.**

Student Name: _____

Student Personal History:

Allergies to Medications: Yes No known drug allergies

If yes, circle all that apply: Penicillin Sulfa Codeine Aspirin Cortisone Iodine Other: _____

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Food Allergies			Eye / Visual Impairment			Kidney / Bladder Problems		
Allergy to Wasp / Bee Stings			Ear / Hearing Impairment			Liver Problems		
Chicken Pox (Mo/Yr)			Nose / Throat Problems			Hepatitis		
Scarlet / Rheumatic Fever			Thyroid / Endocrine Problems			Disease or Injury of Joints		
Head Injuries / Concussion			Diabetes			Arm / Shoulder / Hand Injuries		
Seizures			Lung / Respiratory Problems			Leg / Knee / Foot Injuries		
Recurrent Headaches			Hay Fever, Asthma			Fractures / Broken Bones		
Dizziness / Fainting			Cardiovascular Problems			Back Problem / Injuries		
Weakness / Paralysis			Elevated Blood Pressure			ADD/ADHD		
Insomnia / Sleep Disorder			Heart Murmur			Surgeries:		
Frequent Depression			Skipped Beats / Racing Heart			Appendectomy		
Panic Attacks / Anxiety			Anemia			Tonsillectomy		
Nervous Breakdown			Bleeding Disorder / Sickle Cell			Hernia Repair		
Eating Disorder			Malaria			Other:		
Recent Weight Change			Stomach / Intestinal Problems			Women: Menstrual Problems		
Cancer			Peptic Ulcers					

Comment on "YES" answers: _____

Have you had an illness, injury or hospitalization other than what is already noted? No Yes, explain _____

In the event of an emergency, would you like medical personnel to be aware of any treatment or counseling you have received for a nervous condition, personality disorder, emotional problem, or substance abuse? No Yes, explain _____

List all prescription medications taken on a regular basis: *attach extra sheet if necessary*

Name of Medication	Dosage	How Often Taken	Reason for Taking

Sign This Worksheet:

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) was designed in 1996, to establish national standards of privacy to protect personal health information. HIPAA limits the use and release of individual, identifiable, health information, gives patients the right to access their medical records, restricts most disclosure of health information to the minimum needed for the intended purpose, and establishes safeguards regarding disclosure of records for certain public responsibilities, such as public health, and research and law enforcement. Improper use, or disclosure, of patient information under this rule is subject to criminal and civil sanctions.

I have read and understood the Privacy Notice and I give authorization for release/disclosure of my health information necessary for use by UMHB Health Center unless revoked in writing. If I feel my rights have been violated I will contact the Director of Human Resources at (254) 295-4527.

By signing this worksheet, I/we certify that all parts of this form have been read and the information reported is complete and true.

_____ Student _____ Date

_____ Parent or Guardian _____ Date