STUDENT INFORMATION Please print

Last Name	First	Middle		
Permanent Street Address	City	State	ZIP	Country
Home Phone	Student's Cell Phone	Birth Date		
Marital Status: ❑ Single ❑ Married	Sex: ❑ Male ❑ Female			
Father's Work/Cell Phone	Mother's Work/Cell Phone			
Person to be Notified in an Emergency	Relationship			
Street Address	City	State	ZIP	
(if different from permanent address) Phone				
Name of Physician	Phone	Fax		
Street Address	City	State	ZIP	

MEDICAL INSURANCE — Please attach a copy of the front and back of your insurance card to this form.

NOTE: ENTER YOUR INSURANCE INFORMATION AT RMU.EDU TO AVOID BEING CHARGED FOR INSURANCE

Insurance Company	Group #		
Address	City	State	ZIP
Phone			
Name of Primary Person Insured	Member ID#		

FAMILY HISTORY

	Age	Name	State of Health	Occupation	Age at Death	Cause of Death
Father						
Mother						
Brothers						
Sisters						

PERSONAL HISTORY Please answer all questions. Explain all yes answers below.

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Mononucleosis			Head Injury w/ Unconsciousness			Palpitations (Heart)					
Hepatitis			Frequent Anxiety			High Blood Pressure			List medication and type of reaction		
Chicken Pox			Frequent Depression			Low Blood Pressure					
Gum or Tooth Trouble			Worry or Nervousness			Heart Murmur			ALLERGY TO MEDICATIONS		
Sinusitis			Migraine Headaches			Tumor, Cancer, Cyst					
Eye Trouble			Seasonal Allergy			Gall Bladder Trouble			Allergy to Latex		
Glasses			Chronic Bronchitis			Recurrent Stomach Trouble					
Contacts			Pneumonia			Recent Weight Gain			OTHER:		
Ear Problem			T.B./Positive Test			Recent Weight Loss					
Nose Problem			Shortness of Breath			Eating Disorder					
Throat Problem			Asthma			Dizziness or Fainting					
Diabetes, Type I/II			Chest Pain			Recurrent Kidney Infection					
Seizure Disorder			Chronic Cough			Chronic Diarrhea					
Eczema			Disease/Injury of Joints			Recurrent Constipation					
Insomnia			Hearing Difficulty			Untreated Rupture, Hernia					

Explanation of yes answers:

PHYSICIAN'S HEALTH EVALUATION WITHIN THE CURRENT YEAR

THIS PAGE TO BE FILLED OUT BY PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER

Please review the student's medical history and complete this form. Comment on all positive answers.

Student's Last Name		First		Middle
Date of Birth	Height	Weight	Blood Pressure	Pulse

Are there abnormalities of the following systems? Describe fully.

	NO	YES	Description
1. Head, Ears, Nose or Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Eyes			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			

Is there loss or seriously impaired function of any organ? ❑ No ❑ Yes

If yes, please explain: _____

Are there any required drugs or treatment that must continue while on campus? ❑ No ❑ Yes

Medication/Treatment _____ Dosage/Frequency _____

Is the patient now under treatment for any medical or emotional condition? _____

_____

****IMMUNIZATION INFORMATION MUST BE PRINTED IN SPACE PROVIDED AND IN ENGLISH****

DATE(S) RECEIVED (Mo/Day/Yr)

REQUIRED IMMUNIZATIONS: FIND VACCINATION INFORMATION AT WWW.IMMUNIZE.ORG/VIS				
Hepatitis B Series	1st	2nd	3rd	
Measles, Mumps, Rubella (M.M.R) ***Two doses required***		1st	2nd	
Meningitis vaccine with a quadrivalent meningococcal conjugate vaccine **(MenACWY)** ***ONE DOSE OF MENACTRA IS REQUIRED ON OR AFTER THE 16TH BIRTHDAY***		1st	2nd	
Tetanus Diphtheria Pertussis (Tdap) given between ages 11 and 18 ***Tetanus Diphtheria every 10 years***			Tdap	
Varicella (Chicken Pox)-If no history of disease ***Two doses required***		1st	2nd	
RECOMMENDED IMMUNIZATIONS:				
Hepatitis A		1st	2nd	
HPV Vaccine	1st	2nd	3rd	
Annual Influenza Vaccine (flu shot) **(For Office Use)**	Date	Date	Date	Date

ADDITIONAL IMMUNIZATIONS REQUIRED FOR INTERNATIONAL STUDENTS

DATE(S) RECEIVED (Mo/Day/Yr)

Polio			
Tuberculin Skin Test (within 1 year) = Mantoux	Planted	Read	
or chest X-ray			

PHYSICIAN COMPLETING THIS FORM

Name (Please Print)			
Street Address	City	State	ZIP
Phone	Fax		
Signature	Date of Exam		

PERMISSION FOR TREATMENT

A student signature is required below. A parent/guardian signature is also required if the student is under 18 years of age. I do/ do not give Robert Morris University *My*Health@School permission to administer health care services and treatment to_____.

I give permission to have my medical information reviewed by the athletic trainers at Robert Morris University.

_____

_____ DWH

_____

_____ DWH

_____

CIRCLE ONE: Resident Student Commuter Student

ENTER YOUR HEALTH INSURANCE COVERAGE AT OUR WEBSITE . IF YOU DO NOT, YOU WILL AUTOMATICALLY BE GIVEN RMU INSURANCE AND CHARGED $1918.00.

1. Log on to www.rmu.edu/student insurance
2. Click on the words"**Student Insurance**"
3. You are now in eServices---enter the **STUDENT'S** this must be the student's not a guest username and password. Scroll until you see "**Academic Year 2018-2019**" and the word "**Add**" or "**Update**". Click on the word "Add" or "Update".
4. Continue by entering all fields that are required including the effective date. If there is not an effective date, enter 08/01/2018.

MAIL THIS FORM IN THE ENVELOPE PROVIDED WITH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD TO:

Robert Morris University
*My*Health@School
Jefferson Center
6001 University Boulevard
Moon Township, PA 15108-1189

THIS COMPLETED FORM BEFORE ENTERING ROBERT MORRIS UNIVERSITY