STUDENT HEALTH EVALUATION

INSTRUCTIONS

- All full-time, main campus, traditional students must complete this health evaluation form
- Forms must be received in Student Health Services prior to arrival on campus. Send completed forms to:

  Student Health Services
  Urbana University
  579 College Way
  Urbana, OH 43078
  Fax: 937-772-9384
  E-Mail: healthservices@urbana.edu
- Proof of medical insurance must be submitted online prior to August 31. Information on how to provide insurance proof is e-mailed to each student during the summer. Failure to provide insurance proof and opt-out of university-sponsored health insurance may result in insurance charges applied to the student's account.

Section A:
STUDENT INFORMATION

_____
Last Name First Middle Social Security

_____
Home Address City, State Zip

(_____)_____ (_____)_____
Home Phone Student Cell Phone

_____
Date of Birth Gender Marital Status Religious Preference

_____
High School City & State Year Graduated School Phone Number

I plan to: ☐ Live on Campus - Complete all Sections

☐ Commute to Class - Complete Sections A, B, and E only

Do you plan to participate in any athletic or extracurricular programs? ☐ Yes ☐ No

If yes, which activities: _____

Term you plan to enter: ☐ Fall ☐ Spring ☐ Summer Year you plan to enter: _____

Date form Completed: _____

EMERGENCY CONTACT INFORMATION

_____
Last Name First Relationship Home Phone

_____
Address City, State Zip Work or Cell Phone

Section B:

HEALTH HISTORY

1. Do you have any allergies to any of the following?

	No	Yes	List:
Medications	☐	☐	_____
Inhalants *(pollen, dust, ragweed, molds, grasses, smoke)*	☐	☐	_____
Foods	☐	☐	_____
Chemicals/Contact Substances *(soaps, lotions, cleansers)*	☐	☐	_____
Other Substances	☐	☐	_____

2. Are you currently taking any prescribed medications on a regular or intermittent basis?

☐ No ☐ Yes List: _____

3. Do you have any chronic health problems that require regular treatment?

☐ No ☐ Yes Explain: _____

4. Do you have a disability?

☐ No ☐ Yes Explain: _____

5. Have you ever received professional assistance for any psychological problem?

☐ No ☐ Yes Explain: _____

6. Is there any limitation that would prevent you from participating in sports?

☐ No ☐ Yes Explain: _____

7. Have you had any injuries/surgeries/conditions that might limit your performance in an academic learning experience?

☐ No ☐ Yes Explain: _____

8. Have you had, or have you been immunized against, Measles, Mumps, or Rubella?

☐ No ☐ Yes

If an outbreak of Measles, Mumps, or Rubella occurs, students who do not have immunity to these diseases may be excluded from class and/or residence halls.

COMMUNICABLE DISEASE HISTORY

Please indicate if you have had any of the following diseases:

	No	Uncertain	Yes	Age
Measles	☐	☐	☐	_____
Mumps	☐	☐	☐	_____
Chicken Pox	☐	☐	☐	_____
Whooping Cough	☐	☐	☐	_____
Diphtheria	☐	☐	☐	_____
Polio	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	_____
Rheumatic Fever	☐	☐	☐	_____
Mononucleosis	☐	☐	☐	_____

FAMILY HEALTH HISTORY

Please indicate if any of your blood relatives have had the following:

	No	Yes	Relationship
Diabetes	☐	☐	_____
Stroke	☐	☐	_____
Epilepsy	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Attack/Disease	☐	☐	_____
Asthma	☐	☐	_____
Thyroid Problem	☐	☐	_____
Arthritis	☐	☐	_____
Gout	☐	☐	_____
Obesity	☐	☐	_____
Alcoholism	☐	☐	_____
Cancer	☐	☐	_____

Section C:

IMMUNIZATION HISTORY *for students planning to live on campus only*

The State of Ohio requires universities to maintain records regarding documentation of required immunization of all residential students. Therefore, all students must provide documentation of immunization status to Urbana University. Documentation must include the month, day and year the immunizations were administered.

Required Immunizations include:

- Tetanus/Diphtheria *primary series of Dtap, DTP, DT or Td and a booster within the past 10 years*
- Measles *2 doses of measles vaccine, usually administered as combination MMR, at least 4 weeks apart*
- Polio *primary series in childhood*

Exemptions from Immunization:

1. A medical exemption may be granted based on written statement from a physician that the immunization may be detrimental to the health of the student.
2. A religious exemption may be granted based on a student's written objection to the immunization on religious grounds or strong moral/ethical conviction. A written statement from a physician is also required.

If an outbreak of Measles, Mumps or Rubella occurs, students who do not provide proof of immunity to these diseases may be excluded from classes and/or residence halls.

Residential students must attach a legible copy of immunization records, with name and date of birth, or complete the following:

Immunization	**Dates**			
DTP/Dtap				
Td				
Polio				
Measles				
Mumps				
Rubella				

Section D:

MENINGOCOCCAL AND HEPATITIS B VACCINATION STATUS

I, the undersigned student (if 18 years of age or older) or parent (if student is under 18), have read and understand the information provided to me about Meningococcal Meningitis and Hepatitis B (available at www.urbana.edu/accept). I understand the benefits and risks of being vaccinated against these diseases. The information below regarding my/my student's vaccination status is accurate and is being provided in compliance with the Ohio Revised Code, Section 3701.133(B).

Meningococcal vaccine received: ☐ Yes ☐ No

If yes, date received: _____

Hepatitis B vaccine received: ☐ Yes ☐ No

If yes, date of dose #1: _____

#2: _____

#3: _____

Section E:

SUBMISSION

Student Signature: _____ Date: _____

Parent Signature if under 18 years of age