MICA Student Health Services by Chase Brexton

# Registration Information

## Personal Information

Legal Last Name _____ Legal First Name _____ Middle _____

Social Security Number _____ Date of Birth _____ Marital Status _____ Sex: F M Transgender

Home Address (number and street) _____ City or Town _____ State _____ Zip Code _____

Home Telephone Number _____ Cell Phone Number _____

Preferred language (if other than English) _____

## Emergency Contact Information

Name 1: _____ Relationship: _____

Home phone: _____ Work/Cell Phone: _____

Name 2: _____ Relationship: _____

Home phone: _____ Work/Cell Phone: _____

## Insurance Information

Medical Insurance: _____ Member #:_____ Group #:_____

Policy Holder Name: _____ Policy Holder Date of Birth: _____/_____/_____

Address to send claims (if different than home address): _____

**If available, please attach a copy of the front and back of insurance card**

## Additional Information

Race: American Indian/Alaskan Native_____ Asian _____ Black/African American _____ Hispanic/Latino _____ Multiracial _____
Native Hawaiian/Pacific Islander _____ White_____

Country of Origin (if not United States): _____

Veteran: Yes _____ No _____

## Authorization for Treatment of Minors (if applicable)

If the student has not yet reached their 18th birthday before the beginning of the academic year for which the student is registered, the following authorization by a parent of legal guardian is required.

*I hereby authorize my son/daughter to be treated at MICA Student Health Services if needed, and in case of emergency and in the event that I am unavailable, to be taken to the nearest emergency care center or hospital for appropriate medical treatment.*

Parent/Legal Guardian: _____ Date: _____

## For Office Use Only:

_____ Meningococcal vaccine received or waiver signed

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Date _____

Legal Name (Last, First, Middle) _____ Date of Birth _____/_____/_____

**Personal Health History**

To be completed by student and reviewed by healthcare provider. All information included in this form is confidential and strictly for the use of MICA Student Health Services. Information on this form will not be released to anyone without the knowledge and consent of the student.

| Personal History: Part I | | | |
|---|---|---|---|
| Question | Yes | No | If you select yes, please provide details. |
| Please list all diagnosis for which you have been treated/ hospitalized/ received daily medication/ accessed specialty care. | | | |
| Have you had surgery? (For example, appendectomy, tonsillectomy, hernia repair, etc.) | | | |
| Do you take medication, pills, or use other drugs regularly? Please attach list if applicable. | | | |
| Are you allergic to any medicine? If yes, please list medication and allergic symptom. | | | |
| Do you have allergies to food, insects, stings, or other materials? | | | |
| Do you have any handicap which requires assistance in evacuation in case of an emergency in a classroom or other space? | | | |
| Have you received treatment or counseling for stress, nervous condition, personality or character disorder, or emotional problems? | | | |
| Please list the name, specialty and office telephone number of any consulting providers by whom you are currently being treated. | | | |

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| Personal History: Part II | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Have you had?** | **Yes** | **No** | **Have you had?** | **Yes** | **No** | **Have you had?** | **Yes** | **No** |
| Eczema | | | Shortness of breath | | | Recurrent vomiting | | |
| Acne | | | Asthma | | | Recurrent constipation | | |
| Head injury with unconsciousness | | | Chronic cough | | | Unplanned weight gain (>20 lbs) | | |
| Tumor, cancer, or cyst | | | Cystic fibrosis | | | Unplanned weight loss (<20 lbs) | | |
| Dizziness or fainting | | | Chest pain | | | Hernia | | |
| Eye trouble | | | Palpitations (heart) | | | Hemorrhoids | | |
| Ear problem | | | Rheumatic fever | | | Do you drink alcohol? | | |
| Hearing difficulty | | | Heart murmur | | | Do you use street drugs? | | |
| Nose problem | | | High blood pressure | | | Back problems | | |
| Sinusitis | | | Low blood pressure | | | Disease or injury of joints | | |
| Hayfever | | | Anemia | | | Recurrent Bladder infection | | |
| Gum or tooth trouble | | | Sickle cell | | | Kidney infection | | |
| Throat problem | | | Bleeding disorder | | | Weakness or paralysis | | |
| Neck injury | | | Gastric Reflux | | | Seizures | | |
| Do you smoke cigarettes? | | | Irritable Bowel Syndrome | | | Recurrent headaches | | |
| Bronchitis | | | Gall bladder trouble | | | Insomnia | | |
| Do you use marijuana? | | | Jaundice | | | Frequent anxiety | | |
| Pneumonia | | | Hepatitis | | | Frequent depression | | |
| Tuberculosis | | | Recurrent diarrhea | | | Worry or nervousness | | |
| Mononucleosis | | | Malaria | | | Sports enhancing drugs | | |
| Sexually transmitted disease | | | Diabetes | | | Thyroid problem | | |
| Herpes | | | | | | | | |
| **Females only** | | | | | | | | |
| Irregular periods | | | Severe cramps | | | Excessive flow | | |
| Abnormal pap | | | Pregnancy | | | Cystic breasts | | |
| **Males only** | | | | | | | | |
| Prostate problems | | | Lump or mass in testicle | | | | | |

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| Family History | | | | |
|---|---|---|---|---|
| | Age | Health Status | Health history | Age/Cause of Death (if applicable ) |
| Mother | | | | |
| Father | | | | |
| Sibling | | | | |
| Sibling | | | | |
| Sibling | | | | |

**Are you adopted? Yes _____ No ____**

| Family Illness History - Have any of your blood relatives (parents, siblings, grandparents) ever had any of the following? | | | |
|---|---|---|---|
| Affliction | Yes | No | Relationship |
| Bleeding disorder | | | |
| Tuberculosis | | | |
| Diabetes | | | |
| Kidney disease | | | |
| Arthritis | | | |
| Stomach disease | | | |
| Asthma | | | |
| Hay fever | | | |
| Heart attack/disease | | | |
| Epilepsy | | | |
| Convulsions | | | |
| Cancer | | | |
| High blood pressure | | | |
| Stroke | | | |
| Suicide | | | |
| Alcoholism/addiction | | | |
| Hyperlipidemia | | | |
| High cholesterol | | | |

**The information that I have provided on this health form is accurate, to the best of my knowledge. I understand that all information is maintained as confidential within the MICA Student Health Services.**

Student Signature Date

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## Physical Examination

This portion should be completed by a physician. Please review the student personal health history form and comment on any positive responses.

Legal Name (Last, First, Middle) _____ Date of Birth _____ Biological gender M/F

Blood Pressure _____ Heart Rate _____ Height (in) _____ Weight (lbs) _____ Urine sugar/protein (Y/N)

**Vision:** Right 20/ _____ Left 20/ _____ Both 20/ _____ **Circle one:** With correction Without correction

| System Abnormalities | | |
|---|---|---|
| **System** | **Yes** | **No** |
| Head, ears, nose, or throat | | |
| Respiratory | | |
| Cardiovascular | | |
| Gastrointestinal | | |
| Hernia | | |
| Eyes | | |
| Genitourinary | | |
| Musculoskeletal | | |
| Metabolic/endocrine | | |
| Neuropsychiatric | | |
| Skin | | |

Are there any abnormalities of the systems listed on the left? Describe.

_____

_____

Your recommendations regarding the care of this student would be appreciated.

_____

_____

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

_____

_____

## Fitness Participation

Is the student physically fit to begin a new exercise routine or modify their current one to include the following (mark all that apply):

Resistance training _____ Flexibility training _____ Cardiovascular training _____ Contact sports ____

☐ I am not aware of any contraindications toward participation in an exercise program _____

☐ I believe the student can participate, but urge caution because _____

☐ The applicant should not engage in the following activities _____

☐ I recommend my patient not participate in any of the above activities _____

MICA Student Fitness Center staff is available to discuss modified fitness/exercise programs if requested.

**Please complete attached student vaccination record.**

Physician's Name _____ Physician's Signature _____ Date _____

Address _____ City/Town _____ State _____ Zip Code _____

Telephone _____ Fax _____

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# Student Immunization Record

(Form must be completed and returned before registration.)

**To be completed by the student:**

_____
Last Name First Name Middle Initial

_____ **M F**
Date of Birth Social Security Number Biological Sex (circle)

## MANDATORY IMMUNIZATIONS FOR MICA REGISTRATION

**To be completed and signed by a health care provider.** (Dates must include month, day, and year)

**M.M.R.** (Measles, Mumps, Rubella) **OR** **M.M.R. Titer** (Measles, Mumps, Rubella)

**Option 1**

**Dose 1** – Immunized at 1 year or after
_____/_____/_____

**Dose 2 –** At least 4 weeks after dose 1
_____/_____/_____

**Option 2**

**Lab report of titer** _____

Copy of report must be attached

**Tetanus-Diphtheria**
(Td Booster within last 10 years)

**TD** _____/_____/_____

**Or**

**Tdap** _____/_____/_____

### Meningococcal Vaccine Information

**For individuals 18 years or older:**

I am 18 years of age or older. I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of meningococcal vaccine. I understand that meningococcal disease is rare but life-threatening illness. I understand that Maryland law requires an individual enrolled in an institution of higher education in Maryland who resides on campus in student housing shall receive vaccination against

**Meningococcal Waiver**

I choose to waive the meningococcal vaccine.

_____
_____/_____/_____
Signature of student (parent if student is not 18)

Date _____/_____/_____
_____/_____/_____

**meningococcal waiver must be signed by student/parent.**

**OR** **Meningococcal Vaccine**

**MCV** (Menactra/Menveo)

**OR**

**MPSV** (Menommune)

**If vaccine has not been received,**

### Tuberculin Test

Students must have had a PPD or TB blood test within the last two years, unless there is a history of a positive PPD or TB blood test. Please note: A PPD or TB blood test is required regardless of BCG history.

Date read _____/_____/_____
Interpretation_____

**History of NEGATIVE TB Test**
**test**

Date of test _____/_____/_____
_____/_____/_____
Test used_____

Date read _____/_____/_____
Interpretation_____

**History of POSITIVE TB**

Date of test

Test used_____

## OTHER IMMUNIZATIONS

**Hepatitis B** (recommended)
(Quadrivalent
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____
_____/_____/_____
Dose 3 _____/_____/_____
_____/_____/_____

**Hepatitis A** (recommended)
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____

**Hepatitis A/B**
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____
Dose 3 _____/_____/_____

**Other**
_____
_____

**Varicella**
History of Disease (Year) _____
**OR**
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____

**HPV**
Papillomavirus Vaccine)
Dose 1
Dose 2
Dose 3

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**Health Care Provider (include title):**

| Practitioners signature | Print last name | | | Date |
|---|---|---|---|---|
| Address | City | State | Zip | Phone Number |