

**EMBRY RIDDLE AERONAUTICAL UNIVERSITY
COMPLETED FORM MUST BE RETURNED TO HEALTH SERVICES PRIOR TO ENROLLMENT**

For Office Use Only:
OK to FILE: _____

STUDENT ID# _____

MISSING	X
NEEDS ALL	
MMR1	
MMR2	
HB1	
HB2	
HB3	
MEN	
TB	
CHEST X-RAY	
WAIVERS	X
MMR	
HB	
MNG	

E-mail: _____

Cell#: _____

Will reside in University Housing? Yes _____ No _____

PERSONAL DATA-- Please print legibly

Social Security # ___/___/___ Expected Date of Entry ___/___/___ Degree Program _____

Name _____

Date of Birth ___/___/___ Last First Middle Sex ___ Height ___ Weight ___ Marital Status _____

Permanent Address _____
No. & street City State/Zip Code Country Phone

Emergency Contact _____ Phone (1) _____ (2) _____

PERSONAL MEDICAL HISTORY

Do you have any **allergies**? If so, please indicate (include medications, insect stings, environmental factors, food):

Do you : Smoke? ___ NO ___ YES Use other Tobacco Products? ___ NO ___ YES Consume Alcohol? ___ NO ___ YES

Please check if you are being treated or have been treated in the past for any of the following and **indicate the year**.
Attach a physician statement/summary for any items checked, except chicken pox.

	Year		Year
Alcohol/Drug Dependency		Heart Murmur/Disease	
Anemia, Blood Disease		Hepatitis	
Arthritis, Joint Disease, Bone Disease		High Blood Pressure	
Asthma		Hypoglycemia	
Blood Clot/Phlebitis		Lyme Disease	
Cancer		Malaria	
Chicken Pox		Migraines	
Diabetes (indicate type)		Psychological Problems	
Digestive Disorders		Rheumatic Fever	
Epilepsy, Seizures		Thyroid Disease	
Head Injury		Tuberculosis	
		Other	

Personal physician _____
Name Address Phone

Are you currently under the care of any clinical practitioner for any other condition(s)? **Please list and attach summary.**

List medications taken recently or currently (include birth control, vitamins and herbal preparations):

List operations and/or hospitalizations (include reason and year):

EMBRY RIDDLE AERONAUTICAL UNIVERSITY HEALTH SERVICES

NAME _____ SS# _____ DATE OF BIRTH ____/____/____

REQUIRED IMMUNIZATION DATA

The immunization policy is designed to protect the health of all students. Students who fail to comply will have a HOLD placed on class registration and/or will be denied class attendance pending satisfactory completion of required data.

A licensed health care provider must certify immunization data; home records or self-reports are unacceptable. Copies of school or military immunization records will be accepted with appropriate dates and signatures indicated.

A. MMR (MEASLES/MUMPS/RUBELLA): All students born after Dec. 31, 1956 must provide proof of two doses administered on or after Jan 1,1968 and on or after the first birthday. The second dose of MMR must be administered 30 days or more after the first dose. Alternately, students may provide copies of laboratory reports indicating positive antibody titers for these diseases. Students born prior to Dec. 31, 1956 are considered to have natural immunity.

1st MMR ____/____/____ 2nd MMR ____/____/____

HEPATITIS B AND MENINGOCOCCAL MENINGITIS: We request that you read the accompanying information regarding these diseases and their prevention through vaccination. All students who reside in University Housing must either document the immunizations for Hepatitis B and meningococcal meningitis OR complete the waiver in section B below. We urge you to discuss these concerns with your personal physician and consider vaccination. There will be opportunities for vaccination at campus-sponsored clinics during Orientation and campus-specific dates to be announced.

Hepatitis B dose 1: ____/____/____ Dose 2: ____/____/____ Dose 3: ____/____/____ Meningococcal Meningitis ____/____/____

_____/_____/____ date License # & Office Stamp with Address

B. I have received and read the detailed information provided regarding the risks of contracting meningococcal meningitis and Hepatitis B disease and the potential benefits of being vaccinated to reduce those risks.

___ I decline to receive Hepatitis B vaccines. ___ I decline to be vaccinated for meningococcal meningitis.

_____/_____/____ Date Student Signature Date

AND by parent or legal guardian if under 18 and single

C. RECOMMENDED IMMUNIZATION DATA Polio (most recent dose IPV) ____/____/____ Hepatitis A dose 1 ____/____/____ dose 2 ____/____/____ Td/Tdap(most recent dose) ____/____/____ TB skin test (Mantoux) ____/____/____ mm ____Pos____Neg Varicella (Chicken Pox) ____/____/____

Physician or Authorized Signature Date License # and office stamp with Address

AUTHORIZATION FOR TREATMENT

I hereby grant permission to the Health Services or Counseling Center staff of Embry Riddle Aeronautical University or the University Physician(s) to render any health care or emergency treatment to myself/son/daughter/ward. I also grant permission for the above referenced ERAU staff to arrange for health care, emergency treatment or hospitalization at an accredited hospital or other medical, psychological or dental care facility when considered necessary by the Health Services or Counseling Center staff or University Physician(s).

Signed _____ Date ____/____/____

AND by parent or legal guardian if under 18 and single

Signed _____ Date ____/____/____

EMBRY RIDDLE AERONAUTICAL UNIVERSITY
Please check the campus to which you are applying

___ Daytona Beach Campus
(386) 226-7917
(386) 226-6082 FAX

___ Prescott Campus
(928) 777-6653
(928) 777-3850 FAX

Dear Embry Riddle students and parents,

Welcome to the university! The staff of Health Services is committed to providing you with the health care and preventive education that will support your academic and co-curricular goals. Please read the following important information prior to completing the STUDENT MEDICAL REPORT and returning it to Health Services in the envelope provided. Please make sure that the authorization for treatment, below, has been signed. The information you include in this record is confidential and is not released for students 18 years of age and older without your written consent except in cases of extreme medical emergency or by court order. Parents or legal guardians of students under age 18 have legal access to medical records except for those regarding issues of contraception and sexually transmitted infection. Health Services staff members will use your personal medical information for purposes of diagnosis, care and consultation. Please feel welcome to contact us should you have any questions regarding the completion of this form, immunization requirements or your health care while enrolled at the university.

Sincerely,
Maureen Bridger, M.Ed., RN, BC
Director, Health Services
Daytona Beach Campus

Sincerely,
Sandra F. Palmer, RN, ADN
Director, Health Services
Prescott Campus

IMPORTANT INFORMATION-----PLEASE READ CAREFULLY

HEALTH INSURANCE AND HEALTH CARE EXPENSES: While the Health Services fee covers a range of campus-specific clinical services, fees for specialty care, hospitalization, laboratory tests, radiology studies and pharmacy charges are the responsibility of the individual student. Therefore, we strongly urge students to carry health insurance. **PLEASE ATTACH A COPY, FRONT & BACK, OF YOUR INSURANCE ID CARD, IF ANY.**

NOTE: International students are required to carry health insurance. For specific information, please contact the campus director of International Student Services at assadj@erau.edu (Daytona Beach) or frahera@erau.edu (Prescott).

Please be aware that if you are insured by an HMO (Health Maintenance Organization), you might not be covered for non-emergency services while on campus and outside the plan's network. We urge you to contact your plan administrator for details on your coverage. Also, some health insurance plans are PPOs (Preferred Provider Organization) and require that you use "preferred" clinicians for off campus care that you might require. Your plan administrator can provide you with a list of approved providers for the community in which the campus is located.

A group policy is available for purchase with premiums paid directly to the broker each semester or annually. For additional information on this policy, contact the broker, Student Resources, at 800-237-0903, ext. 6239/6240, or visit www.studentresources.com.

IMPORTANT INFORMATION

Please read the detailed information included with this MEDICAL REPORT form regarding meningococcal meningitis and Hepatitis B disease. Although neither campus has ever experienced an outbreak of bacterial meningitis, a number of college and university campuses across the nation have, sometimes with dire consequences to the life and health of the students, faculty and staff involved. Hepatitis B is a more insidious disease; students can become infected and pass the virus to others before they realize they are ill.

The risk for infection is slightly increased for students, due to the communal nature of the higher education experience. Health Services believes it is important for all students and their parents to be informed and consider the benefits vs. the risks of vaccination. Prior to leaving home, please discuss these concerns with your personal physician.

In an effort to afford students an opportunity to protect themselves, Health Services will sponsor campus clinics to be administered by a national health care firm that specializes in preventive immunization. Clinic schedules and locations will be announced at each campus. Fees associated with these clinics are the responsibility of the individual student.