

## 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.

### IMPORTANT INFORMATION

**Please make sure that the authorization for treatment has been signed.** Health Services staff members will use your personal medical information for purposes of diagnosis, care and consultation. 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.

For the protection of our students, in addition to unlimited use of the services provided by ERAU's student Health Services fee, the university requires all students to participate in the Student Injury and Sickness Insurance Plan unless proof of comparable insurance coverage is provided. All students will be automatically enrolled in the university's student health insurance plan; this plan's benefits may be viewed at [www.uhcsr.com](http://www.uhcsr.com). Students who are currently insured are urged to contact their plan administrator to ensure that benefits can be accessed at their campus of choice. Students having coverage comparable to the university's plan must complete an online Waiver Form found at [www.SRStudentcenter.com](http://www.SRStudentcenter.com) to remove the premium from their student account.

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.

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

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

For Office Use Only:  
OK to FILE:

STUDENT ID# \_\_\_\_\_

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

E-mail: \_\_\_\_\_

Cell#: \_\_\_\_\_

Will reside in University Housing? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does student intend to be vaccinated at Orientation Clinic? \_\_\_\_\_ Yes \_\_\_\_\_ No

**PERSONAL DATA-- Please print legibly**

Social Security # \_\_\_/\_\_\_/\_\_\_ Expected Date of Entry \_\_\_/\_\_\_/\_\_\_ Degree Program \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician or authorized signature \_\_\_\_\_ 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.

Student Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ 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) \_\_\_\_/\_\_\_\_/\_\_\_\_
Varicella (Chicken Pox) \_\_\_\_/\_\_\_\_/\_\_\_\_ TB skin test (Mantoux) \_\_\_\_/\_\_\_\_/\_\_\_\_
\_\_\_\_mm \_\_\_\_Pos\_\_\_\_Neg

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 \_\_\_\_/\_\_\_\_/\_\_\_\_