

The information on this form is confidential and will not be released outside the Health Service without authorization from the student.

NAME \_\_\_\_\_

Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ State/Country of birth \_\_\_\_\_ Middle \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Permanent Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent, Guardian, or Emergency Contact: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Address-if different than above \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Address-if different than above \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Personal Physician \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

<b>Please provide documentation of immunization record</b>				
<b>REQUIRED</b> for University attendance if under 30 years of age				
Measles via <b>one</b> of the following:				
a) MMR - 2 doses after one year of age	1	2		
b) MMR - within 5 years	1			
c) Measles vaccination - 2 doses after one year of age	1	2		
<b>Recommended</b>				
DPT (Diphtheria-Pertussis-Tetanus, ie baby shots)	1	2	3	4
Td (Tetanus-Diphtheria) - within last 5 years	1	2		
Hepatitis B - series of 3 shots	1	2	3	
Varicella (Chicken Pox) - if you have not had the disease	1	2	Date of Disease:	
Menomune (meningococcal meningitis vaccine)	1			
Mumps - if not part of MMR	1			
Rubella - if not part of MMR	1			

For questions 1-7 if your answer is yes, please provide additional information on NEXT page of form. Y N

1	Are you allergic to any medications?		
2	Are you allergic to anything else? (bees, pollen, mold, cats, latex, etc.)		
3	Do you have any chronic health problem or physical condition that requires periodic medical attention?		
4	Do you take any medication, either continuously or intermittently?		
5	Have you had any surgeries or hospitalizations? List date and diagnosis on back of form.		
6	Do other members of your family have any current medical problems? Please list on back of form.		
7	Is there any other information you feel would enhance the Health Service's ability to provide you with good health care? In particular, copies of any physician or hospital records that might be useful.		

The above is true to the best of my knowledge. PERMISSION is hereby granted to the Student Health Service staff to provide treatment/preventive care of this student. PERMISSION is also granted to the Student Health Service to refer this student to another duly licensed physician or surgeon when indicated.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_ Signature of Parent \_\_\_\_\_  
If student is a minor and under 18 years of age, he/she cannot be treated at the Health Service without parental consent as indicated by the above signature. Under an exception to Ohio law, minors can be seen for contraception and sexually transmitted disease treatment without parental consent. If the student is under 18 but not legally a minor, proof of emancipated minor status should be attached.

Complete next page of form as indicated  
Return to: Graduate School  
Miami University  
Oxford, Ohio, 45056

Please use this side for additional information as requested on the first page of the form:

1. Allergic to the following medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Other allergies: \_\_\_\_\_  
\_\_\_\_\_

3. Chronic Health Problems / Physical Conditions that require periodic medical attention: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Continuous Medications and Dosing: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Intermittent Medications and Dosing:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Surgeries and Hospitalizations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Family Medical Problems:

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Other information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_