



Both sides/pages of this form must be submitted. Please return form to: University of Rio Grande Attn: Health Services
P.O. Box 500-Rio Grande, Ohio 45674 • Phone: 740-245-7350 • Email: housing@rio.edu • Fax: 740-245-7341

Last Name _____ First _____ Date of Birth _____
Student ID# _____ Student Mobile _____ Student Dorm/Rm _____

Permanent Home Information	Notify in Case of Medical Emergency
Street Address _____	Name _____ Relationship _____
City _____ State _____ Zip _____	Home Phone _____
Email Address _____	Mobile/Work Phone _____
	Street Address _____
	City _____ State _____ Zip _____

Personal Physician/Healthcare Provider

Name _____ Address _____
Office Phone _____ City _____ State _____ Zip _____
Office Fax _____

Personal Medical History/Disorder/Problem - Please check all that apply

Check if none apply to you

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Dental | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Staph Infections (MRSA) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Migraine | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> GYN | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other please explain _____ |
| <input type="checkbox"/> Cardiac condition | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Seizures | _____ |

Allergies: Drugs & Other Severe Adverse Reactions - List allergy(s) and explain reaction.

Check if you have no allergies

Medication _____ Food _____
Insect _____ Environmental _____
Seasonal _____ X-ray Contrast _____

Are any of these life threatening? Yes No **Do you carry an Epi Pen?** Yes No

Prior Hospitalizations, Surgeries or Orthopedic Procedures - Please list dates and reasons

Medications - Frequent or regular please list all prescriptions, natural and over the counter medications

Is there any other medical information that we should know about? Do you seek healthcare for a condition more than once a year? Please attach any additional information to further explain your condition or concern.

Recommended Immunizations

Tetanus-Diphtheria-Pertussis:

- Completed primary series of tetanus-diphtheria-pertussis immunizations ... Date: ___/___/___
Td or Tdap Booster within the last 10 years ... Date: ___/___/___

Polio (Poliomyelitis):

- Completed primary series of polio immunization ... Date: ___/___/___ Last Booster: ___/___/___

MMR (Measles/Mumps/Rubella):

Recommended vaccine at University of Rio Grande and Rio Grande Community College:

Dates of 2 doses: MMR #1 ___/___/___ MMR #2 ___/___/___ I was born before 01/01/1957. Therefore this vaccination requirement does not apply to me

Hepatitis B: Dates: #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Hepatitis B: surface antibody Result: Reactive Non Reactive Date: ___/___/___

If no, it is recommended that you start the series as soon as possible, as this requires the three doses over a six month period, or a positive Hepatitis B surface antibody meeting the requirements.

Varicella (Chicken Pox): #1 ___/___/___ #2 ___/___/___ or Disease Date: ___/___/___
Antibody Date Titer: ___/___/___ Result: Reactive Non Reactive

Other ___/___/___ Date: ___/___/___ Other ___/___/___ Date: ___/___/___

Meningitis:

The University of Rio Grande and Rio Grande Community College requires mandated vaccination for meningitis. This vaccine is recommended for meningitis. This vaccine is recommended for residential freshmen or any student who is residing in a college dorm at the University of Rio Grande and Rio Grande Community College. This vaccine is given for prevention of bacterial meningitis, which is highly contagious and can be fatal in some cases if exposed.

*New CDC Recommendations (3/11) all Adolescents and teens ages 11 through 18 years should be vaccinated with Menactra or Menveo, as should unvaccinated young adults 19-21 years who are attending college Boosters doses will be necessary for those who got their first dose before age 16 years.

Required vaccine at University of Rio Grande and Rio Grande Community College:

- I have already received the vaccine ___/___/___/ Date of vaccination
No, I have never been vaccinated. I take responsibility for obtaining the vaccine since it is required for all residential students.
No, I have never been vaccinated. I chose to opt out of the mandatory vaccine for personal reasons.

SIGNATURE REQUIRED

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. I understand the benefits and risks of being vaccinated against these diseases. The information above regarding my/my student's vaccination status is accurate and is being provided in compliance with the Ohio Revised Code, Section 3701.133,(B).

My signature below signifies the medical history in-formation provided is true and complete to the best of my knowledge. I further acknowledge receipt and understanding of the immunization information provided by Health Services.

Student Signature _____ Date _____

Parent or Guardian Signature (if student is under 18) _____ Date _____