



**2018-2019
MCU Medical Information
ALL MCU STUDENTS**

Marymount California University is committed to creating and supporting a healthy academic community. We respect and adhere to all HIPPA protected regulations regarding each student's health and medical records. We recognize that varying academic programs in multi-sites may offer different levels of medical service. Based on the services provided, varied medical information is needed.

Section 1: Student Information and Emergency Contact

- Required for all students.
- Completed by student.
- If student under the age of 18, must be signed by parent/guardian

Section 2: Immunizations - Confidential

- Required for all students.
- Completed by medical provider (nurse practitioner, physician's assistant, or medical doctor).

Scan, fax, or mail completed documents to the Student Wellness Center.

Fall Deadline: July 15. Spring Deadline: December 1st.

- Direct Fax #: (310) 303-7379
- Email: Dianne Bettis, Administrative Assistant dbettis@marymountcalifornia.edu or Wellness@marymountcalifornia.edu
- Phone Number: (310) 303-7244
- Osmara Reyes-Osorio, M.S.W./LCSW, Interim Director – Student Wellness Center

**Student Wellness Center
Marymount California University
30800 Palos Verdes Dr. East
Rancho Palos Verdes, CA 90275**

Section 1: Student Information and Emergency Contact

- Required for all students.
- Completed by student.
- If student under the age of 18, must be signed by parent/guardian.
- This information is not confidential and will be shared with MCU departments as necessary

PLEASE TYPE OR PRINT THE FOLLOWING IN BLACK INK AND IN THE ENGLISH LANGUAGE.

Name: _____ **Student ID#:** _____
LAST FIRST MIDDLE INITIAL

Date of Birth: ____/____/____ Email: _____ Male Female Transgender

Address: _____ Mobile Phone: _____

City/State/Zip/Country: _____

Be sure that MCU has your current address and contact information. Updates to this information can be made by complete the Change of Address form at www.marymountcalifornia.edu/registrar-forms.

In order to assure prompt treatment, particularly in emergencies, the following information should be specific and current.

EMERGENCY CONTACT INFORMATION

NAME: _____ Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

City/ State/ Zip/ Country: _____

NAME: _____ Relationship to Student: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

City/ State/ Zip/ Country: _____

The following personal medical history may be shared in the event of a medical emergency:

1. List any medications you are currently taking (include nonprescription drugs): _____
2. Are you allergic to any medications? Yes No If yes, list: _____
3. Have you had an allergic reaction to any food, insect stings or other substances? Yes No If yes, explain: _____

The Information shared below is **CONFIDENTIAL**

PERSONAL HISTORY

1. Have you ever had surgery/hospitalizations? Yes No If yes, explain: _____

2. Have you ever had any significant injuries or medical illnesses/conditions? Yes No

If yes, explain:

PSYCHOLOGICAL HISTORY

If you are currently seeing a psychologist, psychiatrist or therapist and would like to provide the information, please complete the area below:

Therapist's Name _____ Telephone: _____

Address: _____

City/ State/ Zip/ Country: _____

INSURANCE CARRIER

*Completing this section does not waive you out of SHIP, you must complete the SHIP waiver annually prior to add/drop date through the waiver portal. International students are automatically enrolled in SHIP.

MCU Student Health Insurance Plan (SHIP) Personal Insurance (attach copy of ID card/both sides)

Company Name: _____ Policy Number: _____

Company Phone Number: _____

Address: _____

City/ State/ Zip/ Country: _____

IN CASE OF EMERGENCY

I hereby grant Marymount California University the following permission:

1. In case of illness, accident or after hours, students will be referred to Urgent Care, Private Physician, ER or Emergency Response Services will be called.
2. In case of a medical emergency, MCU is permitted to information that students have provided on this form regarding medication and existing allergies.
3. In case of serious illness or accident please complete the following if you would like your private physician to be contacted.

PHYSICIAN'S NAME: _____ Telephone: _____

Address: _____

City/ State/ Zip: _____

RELEASE OF LIABILITY & PERMISSION FOR TREATMENT STATEMENT

By signing this form below, I agree to the following:

- 1) I do hereby state that I have legal custody of the aforementioned student and/or minor.
- 2) I grant authorization and consent for Marymount California University staff/faculty (hereafter "staff") to administer general first-aid treatment for any minor injuries or illnesses experienced by the student.
- 3) If the injury and/or illness is life threatening or in need of emergency treatment, I authorize the Staff to summon any and all professional emergency personnel to attend, transport, and treat the student and to issue consent for any x-ray, anesthetic, blood transfusion, medication, or other medical treatment or hospital care deemed advisable by, and to be rendered under the general supervision of any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly responsible to practice in the state in which such treatment is to occur.
- 4) I agree to assume financial responsibility for all expenses of such care mentioned above.
- 5) Once medical/hospital treatment is completed, the student may be released back to the Staff.
- 6) I agree to allow the Staff to contact and speak with the student's physician/dentist in the event that I cannot be reached.
- 7) I hereby voluntarily release, hold harmless and agree to indemnify Marymount California University, the Staff and employees from any liability resulting from any claims, suits, procedures, costs, expenses, including attorney's fees, and cause of action of whatever kind or nature, including but not limited to, a claim of Marymount California University's negligence, resulting from any damage, loss, personal injury, disability, medical expenses, property damage or theft, arising from or out of the student's attendance or participation as a Marymount California University student.

My Signature implies that I understand and agree with the above: _____

Date: _____

If you are under the age of 18, your parent/guardian is REQUIRED to sign below.

Print Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Section 2: Immunizations – Confidential- Required for all students to complete.

Name _____ Date of Birth ___/___/___
Last First Male Female Transgendered

TO BE COMPLETED BY HEALTHCARE PROVIDER OR SUBMIT COPY OF OFFICIAL IMMUNIZATION RECORDS (in English)

PART 1: REQUIRED IMMUNIZATIONS

HEPATITIS B:

1st Dose: ___/___/___ 2nd Dose: ___/___/___ 3rd Dose: ___/___/___, OR positive titer: ___/___/___

MEASELS- MUMPS-RUBELLA (M.M.R.): Two doses at least 28 days apart for students born after 1956)

1st Dose: ___/___/___ 2nd Dose: ___/___/___, OR positive titer: ___/___/___

TETANUS-DIPHTHERIA-PERTUSSIS(Tdap): Primary Series AND Tdap booster after age 11

Date Tdap booster given: ___/___/___ (Within last 10 years)

VARICELLA (Chicken Pox):

Year of disease: _____, OR 1st Dose: ___/___/___ 2nd Dose ___/___/___, OR positive titer: ___/___/___

PART 2: T.B. SKIN TEST OR CHEST X-RAY – Within 1 year

Date of Test _____ Date of Reading _____ Results _____

For Chest X-ray, please attach copy of result report

PART 3: RECOMMENDED VACCINES

MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) : One or 2 doses for all college students; revaccinate every 5 years if increased risk continue; administer simultaneously with Tdap if possible.

1st Dose: ___/___/___ 2nd Dose: (If applicable) ___/___/___

MENINGOCOCCAL SEROUGROUP B – Two or three dose series; may be given to any college student or for outbreak control; may be given with quadrivalent meningococcal vaccine at different anatomic site. Must complete series with the same vaccine

MenB-RC (Bexsero): Dose #1 ___/___/___ Dose #2 ___/___/___

OR MenB-FHbp (Trumemba): Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___

HEPATITIS A:

1st Dose: ___/___/___ 2nd Dose: ___/___/___

HPV:

1st Dose: ___/___/___ 2nd Dose: ___/___/___ 3rd Dose: ___/___/___

Influenza Vaccine:

Trivalent (IIV3) ___ Quadrivalent (IIV4) ___ Recombination (RIV3) ___ Live attenuated influenza vaccine (LAIV) ___

Date of last dose: ___/___/___

Name of Provider License Number

Signature of Provider Date