HEALTH AND IMMUNIZATION FORM

Welcome to Anderson University! We are glad you have chosen AU to meet your higher education goals. According to University policy, a completed Health & Immunization Form is required of all students. We look forward to serving your health care needs while you are a student at AU.

The Health and Immunization Form contains valuable information including medical history, allergies and immunizations. This information enables us to provide you with the best possible care. Information provided will not affect admission but must be completed and on file in Health Services before classes begin. **Failure to meet this requirement may result in a hold on your account and a delay in your ability to register for classes.**

Information is strictly for use by Health Services and will not be released without the student’s consent. Health records will be maintained for 5 years after a student has graduated or left the university. After that time the record will be destroyed in an approved manner.

Pages that must be completed.

**CHECKLIST FOR COMPLETING THIS FORM:**
- Page 2 - Medical History Form. Read and sign Medical Financial Responsibility section. Complete and attach a copy of the front and back of your health insurance card.
- Page 3 - Provide a copy of an *Official Immunization Record to include:
  - 2 dates MMR
  - Tetanus (Tdap) given within 10 years
  - Meningitis section: Either provide a date of immunization or sign declination
- Page 4 - Tuberculosis screening questions.

* Official Immunization Records Include:
  - Personal shot records that are verified by a doctor’s stamp or signature.
  - Personal shot records with a clinic or health department stamp.
  - Military records or World Health Organization (WHO) documents.
  - Previous college or university records that are verified. (Please note that your immunization records do not transfer automatically, you must request a copy from your school).
  - Positive laboratory test as confirmation of immunity.

MAIL, FAX, OR EMAIL COMPLETED FORMS PRIOR TO DEADLINE.

**FALL ADMISSION:** MAY 1st  
**SPRING ADMISSION:** DECEMBER 1ST

**MAIL TO:** Anderson University Health Center  
316 Boulevard, Box 984  
Anderson, S.C. 29621

**FAX TO:** 864-622-6013

**EMAIL TO:** dtaylor@andersonuniversity.edu

**IMPORTANT DETAILS:**
- This form is required for all undergraduate students
- **ATHLETES:** This form is required IN ADDITION to the forms required by the Athletic Department
- Immunization records from a doctor’s office, health department, the military or a previous school may be submitted in place of this form. While we accept these forms, you must submit the TB risk assessment and the meningitis section. All records must be verified with a healthcare provider’s signature or stamp.

**REVIEW YOUR HEALTH FORM TO ENSURE YOU HAVE COMPLETED ALL PAGES AS INSTRUCTED** (refer to the Checklist above). **NOW THAT YOUR FORM IS COMPLETE PLEASE MAKE A COPY OF ALL RECORDS PRIOR TO SUBMITTING TO AU HEALTH SERVICES.**
HEALTH SERVICE CENTER
316 Boulevard  .  Anderson, SC 29621

MEDICAL HISTORY FORM

(PLEASE PRINT OR TYPE)

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle name</th>
<th>Student ID#</th>
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<tr>
<th>Date of Birth</th>
<th>Male/Female</th>
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<th>Permanent Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone</th>
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<tr>
<th>Local Address (Commuter)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone</th>
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Student Cell Phone

ATHLETE: Yes ___ No ___ Sport ____________

(DOES NOT INCLUDE HIGH SCHOOL OR INTRAMURAL SPORTS)

*IF YOU ARE AN ATHLETE YOU ARE REQUIRED TO FILL OUT THIS FORM IN ADDITION TO THE FORMS REQUIRED BY THE ATHLETIC DEPARTMENT.

SEMESTER YOU PLAN TO ENTER: □ Fall □ Spring Year __________ □ Resident □ Commuter

CLASS: □ Freshman □ Sophomore □ Junior □ Senior □ Graduate □ Adult Studies

IN CASE OF EMERGENCY, NOTIFY

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<thead>
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<th>Last name</th>
<th>Relationship</th>
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<tr>
<th>Work Phone</th>
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CONSENT FOR EMERGENCY NOTIFICATION [Read, sign and date]

I consent to Anderson University’s disclosure to my parents or guardian the fact that I have been transported to an emergency room, hospitalized or deemed by the University Health Center nurses to have a serious physical or mental illness.

This consent to provide this information shall remain in full force during my enrollment at the University unless I revoke it in writing and deliver to the University’s Health Center.

Consent GIVEN: SIGNATURE OF STUDENT __________________________ DATE ____________

Consent DENIED: SIGNATURE OF STUDENT __________________________ DATE ____________
MEDICAL HISTORY FORM

PERSONAL HISTORY

ALLERGIC TO:    YES   NO

Medication:  
  Peanuts
  Bees/Wasps
  Other:

Explain reaction:

· HEALTH INSURANCE COVERAGE IS HIGHLY RECOMMENDED

· MEDICAL FINANCIAL RESPONSIBILITY
  In the event of serious illness or accident, you may require urgent medical care. Fee for services for, but not limited to, transportation ___ (ambulance) to the Emergency Department or treatment at a medical facility will be the responsibility of the guarantor (parent, guardian, or student).

MEDICAL INSURANCE INFORMATION

Do you have HEALTH INSURANCE?  □ Yes  □ No  If YES, please complete the following.

1. INFORMATION FOR PERSON WHO CARRIES THE INSURANCE

   NAME______________________________________________________________________________________________

   DATE OF BIRTH _____ / _____ / _________

   IN THE SPACE BELOW “TAPE” (DO NOT STAPLE) A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD.

   2. CHECK WITH YOUR INSURANCE COMPANY TO BE CERTAIN YOUR STUDENT HAS COVERAGE WHILE RESIDING AT ANDERSON UNIVERSITY.

   4. STUDENT SHOULD KEEP A COPY OF THE CARD WHILE AT ANDERSON UNIVERSITY.

FRONT OF CARD  BACK OF CARD
**IMMUNIZATION RECORD**

You may be able to obtain a copy of your immunization records from any of the following:
- High School records
- Military records
- Personal shot record
- Previous College or University

Anderson University follows the recommendations of the American College Health Association, the South Carolina Department of Health and the US Centers for Disease Control for the immunizations below. You must provide proof of the following.

**REQUIRED IMMUNIZATIONS**

1. **MMR (Measles, Mumps, Rubella):** Proof of TWO DOSES or attach a copy of titer (serologic evidence of immunity) and date.

   - **Dose 1** - given at age 12 months of age or later
   - **Dose 2** - given at age 4-6 years or later, and at least one month after the first dose

2. **Tetanus-Diphtheria:**

3. **Meningococcal Vaccine**
   Proof of a conjugate meningococcal vaccine (e.g. Menactra, Menveo) or a signed waiver declining the vaccine is required of all entering students age 21 years or younger. If conjugate vaccine was received prior to age 16, a booster is required. **A parent/legal guardian’s signature is required if students under the age of 18 decline this vaccination.**

   - **Initial Vaccine**
     - Menveo (11-12 yrs.) Date Given: _____/_____/______
     - MENACTRA (11-12 yrs) Date Given: _____/_____/______

   - **Booster Vaccine (if initial vaccine given prior to age 16.)**
     - MENVEO Date Given: _____/_____/______
     - Menactra Date Given: _____/_____/______

   **Meningococcal Vaccine Waiver:**
   I have read the CDC.gov recommendations and understand the risk of the Meningococcal disease and I am declining to receive the vaccine.

   **Declined Meningococcal Vaccinations**

   Signature_________________________________________ Date _____/_____/______
   Printed Name_______________________________________ Date _____/_____/______
   Parent/Legal Guardian Signature_______________________ Date _____/_____/______

The above vaccines are **REQUIRED OR RECOMMENDED** as part of Anderson University’s mandatory Health Form; however, there are additional vaccines that are recommended by the CDC. We encourage you to discuss these vaccines with your health care professional.
Tuberculosis (TB) Screening Questionnaire

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever had a POSITIVE TB skin test?
   - Yes
   - No

2. Have you lived or had frequent or prolonged visits to one or more of the countries or territories listed below?
   (If yes, CIRCLE the country)
   - Yes
   - No

If the answer is NO to all the questions
   STOP
   No further action is required.

If the answer is YES to any of the questions
   GO
   get a TB skin test and provide documentation.

HIGH RISK COUNTRIES*