MARYMOUNT
CALIFORNIA UNIVERSITY

# MCU Medical Information

All MCU Students | 2021-2022

Marymount California University is committed to creating and supporting a healthy academic community. We respect and adhere to all Health Insurance Portability and Accountability Act (HIPAA)-protected regulations regarding each student's health and medical records.

**Email or fax completed documents to the Student Wellness Center. Fall deadline: July 15. Spring deadline: December 1.**


**Osmara Reyes-Osorio, MSW, LCSW, EdD**
Director
Student Wellness Center
wellness@marymountcalifornia.edu
(310) 303-7244
(310) 303-7379 (fax)

**Dianne Bettis**
Insurance/Office Coordinator
Student Wellness Center
dbettis@marymountcalifornia.edu


## Section 1: Student Information and Emergency Contact

This section must be completed by all students. Students under the age of 18 must have a parent/guardian signature. 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 ENGLISH.**

Name _____ Student ID# _____
LAST FIRST MIDDLE INITIAL

Date of Birth __/ __/ __ Email _____ ☐ Male ☐ Female ☐ Other_____

Address _____ Mobile Phone _____

City/State/Zip/Country _____

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

Name _____ Relationship to Student _____

Home Phone _____ Cell Phone _____

Home Address _____

City/ State/ Zip/ Country _____ Email _____

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**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: _____

3. List any medical/psychiatric conditions we should be aware of (example: anemia, depression, etc.):

_____

_____

## 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 _____ Phone _____

Address _____

City/ State/ Zip/ Country _____ Email _____

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## INSURANCE CARRIER

**Completing this section is not a waiver of the MCU Student Health Insurance Plan (SHIP). To waive the MCU Student Health Insurance Plan (SHIP), students must complete the SHIP waiver prior to add/drop through the waiver portal. Please note international students are automatically enrolled in SHIP.*

☐ MCU Student Health Insurance Plan (SHIP) or
☐ Personal Insurance (Attach copy of front and back of insurance card. Note this does not waive you out of SHIP.)

Company Name _____ Policy Number _____

Company Phone Number _____

## IN CASE OF EMERGENCY

In case of an illness, accident or after hours, students will be referred to urgent care, a private physician or a hospital emergency room. In case of a medical emergency, MCU is permitted to release information students have provided on this form regarding medication and existing allergies. In case of serious illness or accident, complete the following to notify your private physician.

Physician's Name _____ Phone _____

Address _____

## RELEASE OF LIABILITY AND 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 threating or in need of emergency treatment, I authorize 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 the emergency contact and/or guardian 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.

Print Name: _____

Signature: _____ 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:_____

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

Name _____ Student ID# _____
LAST FIRST MIDDLE INITIAL

Date of Birth __/ __ / __ Email _____ ☐ Male ☐ Female ☐ Other_____

**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 ___/___/___
MEASLES- 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-DIPTHERIA-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 ___/___/___

COVID-19: 1ST Dose ___/___/___ 2nd Dose ___/___/___ Product Name/Manufacturer Lot # _____

**PART 2: T.B. SKIN TEST OR CHEST X-RAY** – Within 1 year before entering MCU (ie. between 8/2020 & 8/2021)

Date of Test _____ Date of Reading _____ Results _____
For Chest X-ray, please attach copy of result report

**PART 3: RECOMMENDED VACCINES**
INFLUENZA VACCINE: Trivalent (IIV3)___ Quadrivalent (IIV4)___ Recombination (RIV3)___ Live attenuated influenza vaccine (LAIV) ___ Adjuvanted inactivated influenza (aIIV3) ___ Date of last dose: ___/___/___

MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135): One or 2 doses for all college students; revaccinate every 5 years if increased risk continues; 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 ___/___/___

NAME OF PROVIDER LICENSE NUMBER

SIGNATURE OF PROVIDER DATE

**Office stamp can be placed in lieu of signature. Return to the Student Wellness Center or email wellness@MarymountCalifornia.edu or fax to (310) 303-7379. Questions? Contact the Student Wellness Center at (310) 303-7244.**