MyHealth RMU

WELCOME TO ROBERT MORRIS UNIVERSITY!

STUDENT HEALTH FORM

ALL resident students are required to complete and return this Student Health Form **BEFORE** entering Robert Morris University to the address listed below. Please remember to make a copy of this form for your personal records before mailing. Commuter students are strongly encouraged to also have a completed Health Form on file. **Please note: Athletic Department medical forms, or other medical information that is given to any other department, does not take the place of this form.**

It is the student's responsibility to ensure this form is received in our office before arriving on campus.

Please complete this form in its entirety, as it is required to reside on campus. Return this completed form along with a copy of the front and back of your medical insurance card to the address below, **before** entering Robert Morris University.

ABOUT MyHealth RMU

A registered nurse is on duty to assess student's health, offer appropriate care, provide health education, and make referrals to local health care providers. A telemedicine Advance Practice Provider is available to aid in diagnosis and treatment of minor health issues, all at no charge, no matter which insurance the student carries. Appointments are required. The cost of medications prescribed by the Provider will be the responsibility of the student. MyHealth RMU will aid students in obtaining appointments with Providers in the community if necessary. Any fees incurred in this manner are the responsibility of the student.

CONFIDENTIALITY

Student medical information is considered confidential and will not be released without the student's written consent, except in the following cases:

1. From one healthcare provider to another to achieve continuity of care
2. A health or safety emergency, where disclosure is necessary to protect the health and safety of the student, other students, members of the University community or the public
3. A court-ordered disclosure, or as otherwise permitted or required by law

Under these circumstances, disclosure of student medical information is limited to parties who have a legitimate interest in the welfare of the student and/or the health and safety of the general public.

OFFICE HOURS

Monday–Friday: 8:30a.m.-5:00p.m.

Advance Practice Provider Hours: Monday-Friday 8:30a.m.- 4:00p.m.

FOR MORE INFORMATION

Robert Morris University
MyHealth RMU
6001 University Boulevard
Moon Township, PA 15108-1189

412-397-6220 •Fax: 412-397-6319 •**Email: studenthealthcenter@rmu.edu**

THIS COMPLETED FORM MUST BE RECEIVED AT STUDENT HEALTH SERVICES BEFORE:

AUGUST 1, 2023 FOR FALL SEMESTER

JANUARY 2, 2024 FOR SPRING SEMESTER

R00 ______ RMU STUDENT NUMBER

RMU EMAIL ADDRESS ______

LAST NAME ______

FIRST NAME ______

MIDDLE NAME ______

STUDENT INFORMATION Please print clearly in English. All sections must be completed.

Last Name	First	Middle		
Permanent Street Address	City	State	ZIP	Country
Home Phone	**Student's Cell Phone:**	Birth Date		
Marital Status: ❑ Single ❑ Married	Sex: ❑ Male ❑ Female			
Father's Work/Cell Phone	Mother's Work/Cell Phone			
Person to be Notified in an Emergency	**Relationship**			
Street Address *(if different from permanent address)*	City	State	ZIP	
Phone	Parent's Email:			
Name of Physician	Phone	Fax		
Street Address	City	State	ZIP	

MEDICAL INSURANCE Please also attach a copy of the front and back of your insurance card to this form.

Insurance Company	Group #		
Address	City	State	ZIP
Phone			
Name of Primary Person Insured	Member ID#		

FAMILY HISTORY

	Age	Name	State of Health	Occupation	Age at Death	Cause of Death
Father						
Mother						
Brothers						
Sisters						

PERSONAL HISTORY Please answer all questions. Explain all yes answers below

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Mononucleosis			Attention Disorder			Palpitations (Heart)			Head Injury/Concussion		
Hepatitis			Frequent Anxiety			High Blood Pressure			Date(s)		
Chicken Pox			Frequent Depression			Low Blood Pressure			Cleared?		
Gum or Tooth Trouble			Worry or Nervousness			Heart Murmur					
Sinusitis			Migraine Headaches			Tumor, Cancer, Cyst			ALLERGY TO LATEX?		
Eye Trouble			Seasonal Allergy			Gall Bladder Trouble					
Glasses			Chronic Bronchitis			Recurrent Stomach Trouble			**ALLERGY TO MEDICATIONS**		
Contacts			Pneumonia			Recent Weight Gain			**List medication & reaction**		
Ear Problem			T.B./Positive Test			Recent Weight Loss					
Nose Problem			Shortness of Breath			Eating Disorder					
Throat Problem			Asthma			Dizziness or Fainting					
Diabetes, Type I/II			Chest Pain			Recurrent Kidney Infection			OTHER:		
Seizure Disorder			Chronic Cough			Chronic Diarrhea					
Eczema			Disease/Injury of Joints			Recurrent Constipation					
Insomnia			Hearing Difficulty			Untreated Rupture, Hernia					

Explanation of yes answers:

PHYSICIAN'S HEALTH EVALUATION WITHIN THE CURRENT YEAR

THIS PAGE TO BE FILLED OUT BY PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER

A PRINTED COPY OF A PHYSICAL COMPLETED WITHIN THE PAST 12 MONTHS WILL BE ACCEPTED, PLEASE INCLUDE WITH HEALTH FORM

Please review the student's medical history and complete this form. Comment on all positive answers.

Student's Last Name		First		Middle
Date of Birth	Height	Weight	Blood Pressure	Pulse

Are there abnormalities of the following systems? Describe fully.

	NO	YES	Description
1. Head, Ears, Nose or Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Eyes			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10.Neuropsychiatric			
11. Skin			

Is there loss or seriously impaired function of any organ? ❑ No ❑ Yes

If yes, please explain: ______

Are there any required drugs or treatment that must continue while on campus? ❑ No ❑ Yes

Medication/Treatment______ Dosage/Frequency ______

Is the patient now under treatment for any medical or emotional condition? ______

*****IMMUNIZATION DATES MUST BE ENTERED IN SPACES BELOW, ALSO INCLUDE A COPY OF IMMUNIZATION RECORDS*****

REQUIRED IMMUNIZATIONS: FIND VACCINATION INFORMATION AT WWW.IMMUNIZE.ORG/VIS		****PLEASE DO NOT WRITE ANYTHING BUT DATES IN SPACES BELOW****		
Hepatitis B Series ***Three doses required***		1st	2nd	3rd
Measles, Mumps, Rubella (M.M.R) ***Two doses required***			1st	2nd
Meningitis vaccine with a Quadrivalent Meningococcal Conjugate Vaccine **(MenACWY)** ***ONE DOSE OF MENACTRA IS REQUIRED ON OR AFTER THE 16TH BIRTHDAY***			1st	2nd
Tetanus Diphtheria Pertussis (Tdap) given between ages 11 and 18 ***Tetanus Diphtheria every 10 years***				Tdap
Varicella (Chicken Pox)-If no history of disease ***Two doses required***			1st	2nd
COVID-19 Vaccination ***Primary Series*** Brand:	1st	2nd	3rd	4th
RECOMMENDED IMMUNIZATIONS:				
Hepatitis A			1st	2nd
HPV Vaccine		1st	2nd	3rd
Annual Influenza Vaccine (flu shot)	Date	Date	Date	Date

ADDITIONAL IMMUNIZATIONS REQUIRED FOR INTERNATIONAL STUDENTS **DATE(S) RECEIVED (Mo/Day/Yr)**

Polio Series			
Tuberculin Skin Test(within1year) =Mantoux	Planted	Read	
or chest X-ray			

PHYSICIAN COMPLETING THIS FORM

Name (Please Print)			
Street Address	City	State	ZIP
Phone	Fax		
Signature		Date of Exam	

PERMISSION FOR TREATMENT

A student signature is required below. A parent/guardian signature is also required if the student is under 18 years of age. I do/ do not give Robert Morris University MyHealth RMU permission to administer health care servicesandtreatmentto ______________________________ .

(print student's name)

I give permission to have my medical information reviewed by the athletic trainers at Robert Morris University.

Student signature	**Date**
Parent/guardiansignature(ifunder18)	**Date**
Print parent/guardian name	

PLEASE CIRCLE ONE: **Resident Student (Lives On Campus)** **Commuter Student (Lives Off Campus)**

It is the student's responsibility to ensure this completed form is received in our office before arriving on campus.
Please make sure that all required immunizations have been received and are up to date.

MAIL THIS COMPLETED FORM IN THE ENVELOPE PROVIDED, WITH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD TO:

Robert Morris University
MyHealth RMU
Jefferson Center
6001 University Boulevard
Moon Township, PA 15108-1189
Fax: 412-397-6319 Email: studenthealthcenter@rmu.edu

The Health Form can be faxed or emailed but it must be in English, legible and readable upon receipt.

ALL 4 PAGES OF THIS FORM MUST BE RECEIVED IN OUR OFFICE BEFORE:
AUGUST 1, 2023 FOR FALL SEMESTER
JANUARY 2, 2024 FOR SPRING SEMESTER

7160-04-23