WELCOME TO ROBERT MORRIS UNIVERSITY!

STUDENT HEALTH FORM

ALL resident students are required to complete and return this Student Health Form BEFOREntering 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.

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. Submission of the insurance card does not take the place of entering your insurance information on our website. Directions on how to enter the information is on page 4 of this Health Form.

To avoid being enrolled in the RMU Student Health Insurance Plan, you must enter your insurance information on our website before July 31, 2021 for the 2021/2022 academic year and December 31, 2021 for Spring 2022 semester.

ABOUT UPMC MyHealth@School

A registered nurse is on duty to assess students' 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. The cost of medications prescribed by the Provider will be the responsibility of the student. UPMC MyHealth@School 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. 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

2. A court-ordered disclosure, or as otherwise 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: 8:30 a.m.-5:00 p.m.

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

FOR MORE INFORMATION

Robert Morris University
UPMC MyHealth@School
6001 University Boulevard
Moon Township, PA 15108-1189
412-397-6220 • Fax 412-397-6319 • studenthealthcenter@rmu.edu

THIS COMPLETED FORM MUST BE RECEIVED BY UPMC MyHealth@School BEFORE AUGUST 1, 2021 FOR FALL SEMESTER & JANUARY 3, 2022 FOR SPRING SEMESTER
**STUDENT INFORMATION**  Please print clearly in English. All sections must be completed.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Street Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Home Phone</td>
<td>Student’s Cell Phone:</td>
<td>Birth Date</td>
</tr>
<tr>
<td>Marital Status: ❑ Single ❑ Married</td>
<td>Sex: ❑ Male ❑ Female</td>
<td></td>
</tr>
<tr>
<td>Father’s Work/Cell Phone</td>
<td>Mother’s Work/Cell Phone</td>
<td></td>
</tr>
<tr>
<td>Person to be Notified in an Emergency</td>
<td>Relationship</td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone</td>
<td>Parent’s Email:</td>
<td></td>
</tr>
<tr>
<td>Name of Physician</td>
<td>Phone</td>
<td>Fax</td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

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

NOTE: YOU MUST STILL ENTER YOUR INSURANCE INFORMATION AT RMU.EDU TO AVOID BEING CHARGED FOR RMU INSURANCE

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Group #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Name of Primary Person Insured</td>
<td>Member ID#</td>
</tr>
</tbody>
</table>

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>Age</th>
<th>Name</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Age at Death</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mononucleosis</td>
<td></td>
<td></td>
<td>Positive Result for COVID-19</td>
<td>Yes</td>
<td>No</td>
<td>Palpitations (Heart)</td>
<td>Yes</td>
<td>No</td>
<td>Head Injury/Concussion</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
<td>Frequent Anxiety</td>
<td>Yes</td>
<td>No</td>
<td>High Blood Pressure</td>
<td>Yes</td>
<td>No</td>
<td>Date(s)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
<td>Frequent Depression</td>
<td>Yes</td>
<td>No</td>
<td>Low Blood Pressure</td>
<td>Yes</td>
<td>No</td>
<td>Cleared?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Gum or Tooth Trouble</td>
<td></td>
<td></td>
<td>Worry or Nervousness</td>
<td>Yes</td>
<td>No</td>
<td>Heart Murmur</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sinusitis</td>
<td></td>
<td></td>
<td>Migraine Headaches</td>
<td>Yes</td>
<td>No</td>
<td>Tumor, Cancer, Cyst</td>
<td>Yes</td>
<td>No</td>
<td>ALLERGY TO LATEX?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Eye Trouble</td>
<td></td>
<td></td>
<td>Seasonal Allergy</td>
<td>Yes</td>
<td>No</td>
<td>Gall Bladder Trouble</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Glasses</td>
<td></td>
<td></td>
<td>Chronic Bronchitis</td>
<td>Yes</td>
<td>No</td>
<td>Recurrent Stomach Trouble</td>
<td>Yes</td>
<td>No</td>
<td>ALLERGY TO MEDICATIONS</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Contacts</td>
<td></td>
<td></td>
<td>Pneumonia</td>
<td>Yes</td>
<td>No</td>
<td>Recent Weight Gain</td>
<td>Yes</td>
<td>No</td>
<td>List medication &amp; reaction</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ear Problem</td>
<td></td>
<td></td>
<td>T.B./Positive Test</td>
<td>Yes</td>
<td>No</td>
<td>Recent Weight Loss</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nose Problem</td>
<td></td>
<td></td>
<td>Shortness of Breath</td>
<td>Yes</td>
<td>No</td>
<td>Eating Disorder</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Throat Problem</td>
<td></td>
<td></td>
<td>Asthma</td>
<td>Yes</td>
<td>No</td>
<td>Dizziness or Fainting</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes, Type I/II</td>
<td></td>
<td></td>
<td>Chest Pain</td>
<td>Yes</td>
<td>No</td>
<td>Recurrent Kidney Infection</td>
<td>Yes</td>
<td>No</td>
<td>OTHER:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td></td>
<td></td>
<td>Chronic Cough</td>
<td>Yes</td>
<td>No</td>
<td>Chronic Diarrhea</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
<td></td>
<td>Disease/Injury of Joints</td>
<td>Yes</td>
<td>No</td>
<td>Recurrent Constipation</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
<td></td>
<td>Hearing Difficulty</td>
<td>Yes</td>
<td>No</td>
<td>Untreated Rupture, Hernia</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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

PRINTED COPY OF A PHYSICAL DONE WITHIN THE PAST 12 MONTHS WILL BE ACCEPTED

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

<table>
<thead>
<tr>
<th>Student’s Last Name</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Height</th>
<th>Weight</th>
<th>Blood Pressure</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are there abnormalities of the following systems? Describe fully.

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 INFORMATION MUST BE PRINTED IN SPACES BELOW IN ENGLISH & ALSO INCLUDE A PRINTED COPY* DATE(S) RECEIVED (Mo/Day/Yr)

<table>
<thead>
<tr>
<th>REQUIRED IMMUNIZATIONS: FIND VACCINATION INFORMATION AT <a href="http://WWW.IMMUNIZE.ORG/VIS">WWW.IMMUNIZE.ORG/VIS</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B Series Three doses required</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (M.M.R) Two doses required</td>
</tr>
<tr>
<td>Meningitis vaccine with a Quadrivalent Meningococcal Conjugate Vaccine (MenACWY) ONE DOSE OF MENACTRA IS REQUIRED ON OR AFTER THE 16TH BIRTHDAY</td>
</tr>
<tr>
<td>Tetanus Diphtheria Pertussis (Tdap) given between ages 11 and 18 Tetanus Diphtheria every 10 years 1dap</td>
</tr>
<tr>
<td>Varicella (Chicken Pox) - If no history of disease Two doses required</td>
</tr>
</tbody>
</table>

RECOMMENDED IMMUNIZATIONS:

<table>
<thead>
<tr>
<th>Hepatitis A</th>
<th>1st</th>
<th>2nd</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV Vaccine</td>
<td>1st</td>
<td>2nd</td>
</tr>
<tr>
<td>Annual Influenza Vaccine (flu shot) Date Date Date Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COVID-19 Vaccine Date Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Polio Series</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tuberculosis Skin Test (within 1 year) = Mantoux Planted Read or chest X-ray</th>
</tr>
</thead>
</table>

PHYSICIAN COMPLETING THIS FORM

Name (Please Print) ____________________________________________________________________________

Street Address City State ZIP

Phone Fax

Signature Date of Exam

3
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 UPMC MyHealth@School permission to administer health care services and treatment to ____________________________.

(print student’s name)

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

<table>
<thead>
<tr>
<th>Student signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/guardian signature (if under 18)</td>
<td>Date</td>
</tr>
<tr>
<td>Print parent/guardian name</td>
<td></td>
</tr>
</tbody>
</table>

PLEASE CIRCLE ONE:  Resident Student  Commuter Student

TO AVOID BEING CHARGED FOR RMU INSURANCE, YOU MUST ENTER YOUR HEALTH INSURANCE COVERAGE AT OUR WEBSITE BEFORE JULY 31, 2021 FOR THE UPCOMING ACADEMIC YEAR. IF YOU DO NOT, YOU WILL AUTOMATICALLY BE ENROLLED IN THE RMU STUDENT HEALTH PLAN, AND YOUR RMU STUDENT ACCOUNT WILL BE CHARGED.

1. Log on to www.rmu.edu/student insurance
2. Click on the words “Student Insurance” in the yellow box.
3. You are now in Sentry Secured Services—enter the STUDENT’S user name and password. This must be the student’s not a guest user name and password. Scroll down until you see “Academic Year 2021-2022” and the word “Add” or “Update”. Click on the word “Add” or “Update”.
4. Continue by entering all fields that are required including the effective date.
   If there is not an effective date, enter 08/01/2021. If you do not have a group # enter all zeros.
   If you have Tricare insurance, use your SS# as your Member ID #
5. This process will need to be repeated every year before July 31st.

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

Robert Morris University
UPMC MyHealth@School
Jefferson Center
6001 University Boulevard
Moon Township, PA 15108-1189

THIS COMPLETED FORM MUST BE RECEIVED BY UPMC MyHealth@School BEFORE
AUGUST 1, 2021 FOR FALL SEMESTER & JANUARY 3, 2022 FOR SPRING SEMESTER