*My*Health RMU

R 00

RMU STUDENT NUMBER

RMU EMAIL ADDRESS

LAST NAME

FIRST NAME

MIDDLE NAME

WELCOME TO ROBERT MORRIS UNIVERSITY!

STUDENT HEALTH FORM

ALL resident students are required to complete and return this Student Health Form to the addresses or fax number listed below BEFORE entering Robert Morris University. 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, but it is not required.

Please note: Athletic Department medical forms/immunizations, 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 4-page 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 addresses or fax number below, **before** entering Robert Morris University.

ABOUT *My*Health 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. *My*Health 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 6001 University Blvd Moon Twp. PA, 15108
*My*Health RMU—Jefferson Center
Phone: 412-397-6220 •**Fax:** 412-397-6319
Email: studenthealthcenter@rmu.edu
Website: studenthhealthservices@rmu.edu

THIS FORM MUST BE RECEIVED AT *MY*HEALTH RMU IN JEFFERSON BEFORE:

AUGUST 1, 2026 FOR FALL SEMESTER JANUARY 4, 2027 FOR SPRING SEMESTER

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	City	State	ZIP	
(if different from permanent address) 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/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:

___

REQUIRED IMMUNIZATIONS

All immunizations must be up-to-date, and dates entered into the spaces provided below

Please ONLY enter immunization dates in this section.

REQUIRED IMMUNIZATIONS: **FIND VACCINATION INFORMATION AT WWW.IMMUNIZE.ORG/VIS**				
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 **(Men ACWY)** ***ONE DOSE OF MENACTRA OR MENVEO IS REQUIRED ON OR AFTER THE 16TH BIRTHDAY***			1st	2nd
Tetanus Diphtheria Pertussis (Tdap) is 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
RECOMMENDED IMMUNIZATIONS:				
Meningitis B			1st	2nd
Hepatitis A			1st	2nd
HPV Vaccine		1st	2nd	3rd
Annual Influenza Vaccine (flu shot)	Date	Date	Date	Date
COVID-19 Vaccine	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			

MEDICATION AND SUPPLEMENT LIST- Please list all medications and supplements

Medication	Dosage *mg, etc.*	Frequency	Purpose

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 *My*Health RMU 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.

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

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

It is the student's responsibility to ensure this completed form is received at: *My*Health RMU in Jefferson before arriving on campus.

Please make sure that all required immunizations have been received, are up to date and are written in the spaces provided in the immunization section on this form.
If you have any questions, please call the number below.

This Health Form may be mailed, faxed or emailed to the address or fax number below.
The Health Form must be in English, legible and readable upon receipt.
When emailing the Health Form, it must be sent as a PDF or JPEG file.
HEIC files cannot be opened and will not be accepted.

Mailing Address:
Robert Morris University
*My*Health RMU—Jefferson Center
6001 University Boulevard
Moon Township, PA 15108-1189
Phone: 412-397-6220 •**Fax:** 412-397-6319
Email: studenthealthcenter@rmu.edu
Website: studenthealthservices@rmu.edu

ALL 4 PAGES OF THIS FORM MUST BE COMPLETED & RECEIVED IN OUR OFFICE BEFORE:

AUGUST 1, 2026 FOR FALL SEMESTER

JANUARY 4, 2027 FOR SPRING SEMESTER

7160-03-26