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 3 years after a student has graduated or left the university. After that time the record will be destroyed in an approved manner.

CHECKLIST FOR COMPLETING THIS FORM:

Page 2 - Medical History Form. 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.

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

FALL ADMISSION: AUGUST 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: auhealthforms@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

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.
1. (PLEASE PRINT OR TYPE)

| Last name | First name | Middle name | Student ID# |

| Date of Birth | Male/Female | Country of Birth |

| Permanent Address | City | State | Zip Code | Telephone |

| Local Address (Commuter) | City | State | Zip Code | Telephone |

Student Cell Phone

2. 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.

3. SEMESTER YOU PLAN TO ENTER:  
   - Fall
   - Spring
   - Year ______
   - Resident
   - Commuter

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

4. IN CASE OF EMERGENCY, NOTIFY

| Last name | Relationship |

| Work Phone | Cell Phone | Home Phone |

| Address | City | State | Zip Code |

5. 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

<table>
<thead>
<tr>
<th>Medication:</th>
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<tbody>
<tr>
<td>Peanuts</td>
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<tr>
<td>Bees/Wasps</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Explain reaction:</td>
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</tbody>
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HEALTH SERVICE CENTER
316 Boulevard  .  Anderson, SC 29621

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 ___ / ___ / _______

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

3. 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

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.

THE IMMUNIZATION RECORD MUST BE A COPY OF THE OFFICIAL DOCUMENT OR BE SIGNED OR STAMPED BY A MEDICAL PROFESSIONAL.

You may be able to obtain a copy of your immunization records from any of the following:

- High School records
- Personal shot record
- Military records
- Previous College or University

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
   Meningococcal Vaccine HIGHLY Recommended but not required; however, you are REQUIRED to sign the waiver below if you choose not to receive the vaccine. This pertains to all entering students age 21 years or younger.
   
   Initial Dose (given @ age 11-12 years)
   
   Booster Dose (given if initial vaccine is given prior to age 16)

   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 __/__/____

   *A parent/legal guardian’s signature is required if students under the age of 18 decline this vaccination.

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 close contact with persons known or suspected to have active TB disease?
   - Yes
   - No

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

3. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?
   - Yes
   - No

4. Have you ever been a volunteer or health care worker who served clients who are at increased risk for active TB disease?
   - Yes
   - No

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

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

IF YOU HAVE EVER HAD A POSITIVE TB SKIN TEST, YOU MUST PROVIDE A LETTER OF CLEARANCE FROM YOUR PHYSICIAN.

HIGH RISK COUNTRIES*

Afghanistan  Congo DR  Kenya  New Caledonia  Sudan  Suriname  Syrian Arab Republic  Swaziland  Tajikistan  Tanzania - UR  Thailand  Timor-Leste  Togo  Tokelau  Tonga  Tunisia  Turkey  Turkmenistan  Tuvalu  Uganda  Ukraine  Uruguay  Uzbekistan  Vanuatu  Venezuela  Vietnam  Wallis and Futuna Islands  W. Bank and Gaza Strip  Yemen  Zimbabwe


Argentina  Armenia  Azerbaijan  Bahamas  Bahrain  Bangladesh  Belarus  Belize  Benin  Bhutan  Bolivia  Bosnia and Herzegovina  Botswana  Brazil  Brunei Darussakian  Bulgaria  Burkina Faso  Burundi  Cambodia  Cameroon  Cape Verde  Central African Rep.  Chad  China  Colombia  Comoros  Congo

REVISED AUGUST 2018