**MARYMOUNT UNIVERSITY**

**STUDENT HEALTH SERVICES** Checklist for Students and Parents

**2807 N. Glebe Road, Berg Hall 1014**

**Arlington, VA 22207**

Phone: 703-284-1610

Email: [shealthc@marymount.edu](mailto:shealthc@marymount.edu)

* **Health Compliance:** *If you are fully online you do not need to submit immunizations.*

*ALL FORMS MUST BE COMPLETED OR TRANSLATED INTO ENGLISH*

1. Submit immunization documentation to Student Health Services via [shealthc@marymount.edu](http://shealthc@marymount.edu) before Aug 1, 2024
2. Complete the TB questionnaire and Health History Form.

* **Insurance Compliance**

1. Enroll or waive the Student Health Insurance Plan (SHIP) no later than October 6th, 2024
2. Get a copy of your insurance card before arriving on campus (hard copy or picture)
3. The mandatory insurance fee is automatically added to your MU bill, but removed or refunded once you waive the insurance.

* **General Student Health**

1. Access to Care, Charges, and Fees
2. Local pharmacies
3. If minor, parent/guardian must sign a consent to treat
4. Helpful hints
5. Recommended items to bring with you to campus

|  |
| --- |
| ATHLETES, NURSING STUDENTS, AND PT STUDENTS HAVE PROGRAM SPECIFIC FORMS. STUDENT HEALTH FORMS MUST BE SUBMITTED IN ADDITION TO THE PROGRAM FORMS |

**Access to Care, Charges, and Fees**

**The Student Health Fee,** as part of the tuition and fees package, allows all enrolled students the convenience of accessing health care on campus. The fee covers routine visits, but services such as labs, immunizations, and procedures will be charged. We have a physician, nurse practitioners, and a mental health nurse practitioner (PMHNP) on staff. The Student Health Center is open Monday - Friday, 9am - 5pm.

The PMHNP will follow students that have been diagnosed and started treatment for ADHD. Please review this section on the Student Health web page.

*FACT #1: There is no charge to see a healthcare provider in Student Health Services*

*FACT #2: You do not need to have the Student Health Insurance Plan to be seen in the clinic.*

**Immunizations**

Students are required by Virginia Public Health Law to provide proof of immunizations prior to the start of classes. Detailed instructions are outlined in the medical forms packet, including a TB screening. Once forms are completed please email them to the Student Health Center, [shealthc@marymount.edu](http://shealthc@marymount.edu).

If you require immunizations prior to starting classes, please contact Student Health Services. SHS carries all required vaccines, and will bill insurance for them. \*

***If immunization records are not compliant prior to the first day of class, you may be restricted from attending class.***

**Insurance**

We are currently “in-network” with most Aetna, Blue Cross and Blue Shield, Cigna, and United Healthcare plans. Before providing services (immunizations, etc.) we will confirm that you are eligible for in-network.

*Marymount University believes that health insurance coverage is crucial while students pursue their studies. If a student lacks adequate health insurance, their education could be interrupted or even terminated due to an unexpected illness or injury.*  *Marymount University* ***requires all full-time students*** *to have health insurance. There are two options for student coverage:*

1. **Remain on parent/guardian’s plan:**

* If the parent or guardian of the student has credible insurance and would like for the student to stay on their plan, they can submit a waiver for the Student Health Insurance Plan (SHIP). *You are automatically enrolled if you do not waive*.
* The waiver form can be found by logging into [myMarymount](https://my.marymount.edu/Home).edu and clicking “Student Health Insurance Waiver/ Enrollment” under the Sign On Links.
* Once your insurance is given and approved, the mandatory insurance charge ($2000) will be removed from the student account or reimbursed if tuition has already been paid.
* This waiver must be completed once each academic year.

1. **Enroll into the Student Health Insurance Plan (SHIP) - *United Healthcare*:** If you would like to purchase the SHIP follow these steps

* The enrollment form can be found by logging into [myMarymount](https://my.marymount.edu/Home).edu and clicking “Student Health Insurance Waiver/ Enrollment” under the Sign On Links.
* Once you are enrolled Please visit [United HealthCare Student Resources](https://idp.uhcsr.com/core/Login?ReturnUrl=%2Fcore%2Fconnect%2Fauthorize%2Fcallback%3Fclient_id%3DmyAccount%26redirect_uri%3Dhttps%253A%252F%252Fmyaccount.uhcsr.com%252FauthToken%26post_logout_redirect_uri%3Dhttps%253A%252F%252Fmyaccount.uhcsr.com%252FauthToken%26response_type%3Did_token%2520token%26scope%3Dopenid%2520MyAccountApi.Secure%26state%3D1597760436787%26nonce%3D6671) to learn more about the insurance plan and to print off your insurance card.

*The United Healthcare (SHIP) plans runs from August 17, 2024 until August 16, 2025*

*If you have additional questions about the insurance plan please contact Gallagher Student Health & Special Risk at 1-833-440-0570 (toll free) or by going to* [*Gallagher Student Health & Special Risk website*](https://www.gallagherstudent.com/students/student-home.php?idField=1423&KosterWebSID=v2brao6pk0ajr3o4ngc9vpg620) *and clicking on the Customer Service link.*

**Consent for Care Form**

As the parent or guardian of a student under the age of 18, a consent for care must be completed. Care will not be provided by Student Health Services without a completed form. \*If the situation is life-threatening care will be rendered.

**Release of Information**

Student Health Services follow HIPAA and FERPA guidelines. Parents of students 18 years and older will need to have their child sign a written release before ANY information will be provided. If you would like to obtain this release form, please email the clinic.

**Helpful Health Tips**

1. *Student Health Contact Info* - Add our number (703-284-1610) and email (shealthc@marymount.edu) to your contact list in your phone
2. *Insurance Card -* Take a photo of all of your health insurance cards to keep in your cell phone
3. *Stop by Student Health and say “hello” (Berg 1014)* - Bring a list to school with ALL the medications you take
4. *Glasses/Contacts* - Be sure to have a spare pair of glasses or a copy of your prescription
5. *Allergy-serums* administration and monitoring. There is a $75/semester charge for this type of appointment. *Appointments with the PMHNP (mental health nurse practitioner) will have a $100/semester fee.*
6. *Recommended items to bring with you to campus:* Digital thermometer, acetaminophen, ibuprofen, cold medication, upset stomach medicine, Band-Aids, topical antibacterial cream, and a reusable cold pack.

**Local Pharmacies**

There are multiple pharmacies located within walking distance from the main campus, as well as the Ballston campus, which can be accessed with the university shuttle bus. (CVS, Walgreens, Prestons)

Another option is to use a local pharmacy that delivers medication to the students for free. The name is Capsule and it is located in Washington, DC. If you take any medication for a chronic condition, please make sure you have an adequate supply, transfer the prescription or have a copy of the prescription. Student Health does not manage chronic conditions, except Attention Deficit Disorder.

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| --- | --- |
| **CVS**4709-A LEE HIGHWAYARLINGTON, VA, 22207 (703) 522-0011 4238 WILSON BLVD/BALLSTON COMMONS #1831ARLINGTON, VA, 22203(703) 243-5944 | **Preston’s Pharmacy**  5101 LANGSTON BLVD  ARLINGTON, VA, 22207  (703) 522-3412 |
| **Walgreens**  4720-B LANGSTON BLVD  ARLINGTON, VA, 22207  (703)524-9003 | **Harris Teeter**  2425 HARRISON STREET  ARLINGTON, VA 22207  (703) 532-8663 |

**MARYMOUNT UNIVERSITY**

**STUDENT HEALTH SERVICES** Health History

* **Email** Health History Record pages to Student Health Center: healthhx@marymount.edu
* **DUE**: August 1 (Fall Admission) January 1 (Spring Admission) May 1 (Summer Admission)
* Do not include forms for other departments in your upload. ALL STUDENTS
* If you are a FULLY online student please let us know, since these forms are not required

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_

*Last First Middle MM /DD / YYYY*

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_

* Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please check the preferred number.
* Student’s Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ◻ Male ◻ Female ◻ Other Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY (Please check all that apply and explain any “Yes” answers below)**

|  |  |  |
| --- | --- | --- |
| YES NO | YES NO | YES NO |
| □ □ Allergies (seasonal/annual) | □ □ Eating Disorder | □ □ Rheumatic Fever |
| □ □ Anemia | □ □ Gastrointestinal Problems | □ □ Tuberculosis |
| □ □ Asthma/Exercise-induced | □ □ Gynecological Problems | □ □ Sexually Transmitted Diseas |
| □ □ Bone/Joint Disorder | □ □ Frequent Headaches | □ □ Elevated Cholesterol |
| □ □ Cancer | □ □ Heart Disease | □ □ High Blood Pressure |
| □ □ Chicken Pox | □ □ Hepatitis/Liver Disease | □ □ Frequent Throat Infections |
| □ □ Circulatory Problems/Clots | □ □ Kidney/Urinary Problems | □ □ Frequent Ear Infections |
| □ □ Convulsions/Seizure/Epilepsy | □ □ Mental Health | □ □ ADD/ADHD |
| □ □ Diabetes | □ □ Mononucleosis | □ □ Other – Explain below |

Current Diagnosis, Medications & Dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: medication/foods, etc. (include reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant illness/hospitalization (include dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of psychiatric/psychological conditions (ex. Anxiety 1/12- present): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to be notified in case of emergency: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MARYMOUNT UNIVERSITY**

**STUDENT HEALTH SERVICES IMMUNIZATION FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (M/D/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUIRED**

|  |
| --- |
| **MMR (Measles, Mumps, Rubella) -** *2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps, and/or Rubella. Only need to complete if born Choose only one option. IF YOU WERE BORN PRIOR TO JANUARY 1, 1956 YOU ARE EXEMPT* |

**Option 1**  Vaccine Date

|  |  |  |  |
| --- | --- | --- | --- |
| **MMR**  *2 doses of MMR vaccine* | MMR Dose #1  MMR Dose #2 |  |  |

**Option 2**  Vaccine or Test Date Serology Results

|  |  |  |  |
| --- | --- | --- | --- |
| **Measles**  *2 doses of vaccine or positive serology* | Measles Vaccine #1  Measles Vaccine #2  Serologic Immunity (IgG antibody titer) |  | Qualitative Test Results:  ☐ Positive ☐ Negative  Quantitative Titer Results:  \_\_\_\_\_\_\_\_\_\_\_IU/m |
| **Mumps**  *2 doses of vaccine or positive serology* | Mumps Vaccine #1  Mumps Vaccine #2  Serologic Immunity (IgG antibody titer) |  | Qualitative Test Results:  ☐ Positive ☐ Negative  Quantitative Titer Results:  \_\_\_\_\_\_\_\_\_\_\_IU/m |
| **Rubella**  1 dose of vaccine or positive serology | Rubella Vaccine  Serologic Immunity (IgG antibody titer) |  | Qualitative Test Results:  ☐ Positive ☐ Negative  Quantitative Titer Results:  \_\_\_\_\_\_\_\_\_\_\_IU/m |

**Tetanus-diphtheria-pertussis** - *1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of booster*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Tdap Vaccine  (Boostrix, Adacel, etc.)  Td Vaccine or Tdap Vaccine booster (if more than 10 years since last) |  |  |

MU SHS Immunization Record (cont.)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Meningococcal** -*1 dose between the age of 16 years to 23 years*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Meningococcal Vaccine |  |  |

**Meningitis B -** *2 doses or have started the 2 dose series between the age of 16-23 years*

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Bexsero  ☐ Trumenba | Men B #1  Men B #2 |  |  |

**Hepatitis B** -  *2 or 3 dose series* ***OR*** *signed WAIVER*

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Engerix-B/Recombivax  ☐ Heplisav-B (2 doses) | Hepatitis #1  Hepatitis #2  Hepatitis #3 |  | Qualitative Test Results:  Immune ☐ Yes ☐ No  Quantitative Titer Results:  \_\_\_\_\_\_\_\_\_\_\_mIU/mL |

**Polio -** *for students under 18 years*

|  |  |  |  |
| --- | --- | --- | --- |
| Polio (IPV) | Date series completed: |  |  |

**NOT REQUIRED, BUT RECOMMENDED:**

|  |  |  |  |
| --- | --- | --- | --- |
| Hepatitis A | #1 | #2 |  |
| COVID | #1 | #2 | #3 |
| Varicella | #1 | #2 |  |

|  |  |
| --- | --- |
| Providers official address: | Stamp: |
| Signature of HCP: | Date: |

**\*** *Student Health Clinic carries all required vaccinations if unable to get prior to coming to campus. Your insurance will be verified prior to administration. Please call 703-284-1610 if you have questions or would like to make an appointment.*

*\*\* Only students attending classes in-person need to submit immunizations. If you are online, please let SHS know.*

**MARYMOUNT UNIVERSITY**

**STUDENT HEALTH SERVICES** TB Screening

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (M/D/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tuberculosis Risk Self-Assessment (TBRA)**

**Student completes upon initial entrance to school**

1. **Have you ever had a positive tuberculosis (TB) test?**  **NO \_\_ YES \_\_** \*If you have had a positive TB test in the past you must submit documentation of the positive test, including chest x-ray report and treatment records. Further testing may not be required.
2. **Do you have any of the following signs or symptoms of active TB disease?**  **NO \_\_ YES \_\_**

* Unexplained fever/chills for more than 1 week
* Persistent cough of unknown etiology for more that 3 weeks
* Cough with bloody sputum
* Night sweats
* Unexplained weight loss
* Unexplained fatigue

1. **Do any of the following situations apply to you? NO\_\_ YES\_\_**

* Close contact with a person known or suspected to have TB
* Use of any illegal injectable drugs
* At risk for Human Immunodeficiency Virus (HIV) Infection
* Volunteered, resided, or worked in a healthcare facility or congregate living setting

(homeless shelter, nursing home, or correctional facility) for longer than 1 month

* History of silicosis, diabetes, renal disease, blood disorders or cancer
* History of gastrectomy, jejunoileal bypass, or chronic malabsorptive condition
* History of a solid organ transplant (kidney, heart, liver)
* Immunosuppressive therapy, such as prolonged corticosteroid therapy, chemotherapy, OR TNF-antagonist medications (Humira, Enbrel, Remicade) OR JAK-inhibitor medications (Xeljanz, Rinvoz, Jyseleca)
* Are less than 10% of normal body weight or malnourished

1. **Within the past 5 years, have you traveled to or lived in any of the following areas for more than one (1) month? NO \_\_ YES\_\_**

Africa, Asia, Central America, Cuba, Dominican Republic, Eastern Europe, Haiti, India and other Indian subcontinent nations, Middle East (except Egypt, Saudi Arabia, Jordan, Lebanon, UAE), Portugal, South America, South Pacific (except Australia and New Zealand.

<https://www.vdh.virginia.gov/content/uploads/sites/175/2022/02/High-Burden-TB-Countries-2022.pdf>

Student Signature (*or guardian if under 18)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

**If you answered “yes” to any question above, TB testing is required.**

If you have questions regarding testing for TB please contact the Student Health Center (703) 284-1610. Please bring copies of any further testing with the date and results.

**MARYMOUNT UNIVERSITY**

**STUDENT HEALTH SERVICES Consent to Treat Minor Patients**Virginia State law requires consent of a parent/legal guardian for medical care of minors. If your son or daughter is enrolled at Marymount University prior to his/her eighteenth birthday and they seek care at the Student Health Center, you must complete and return the following consent to:

Marymount University Student Health Center

(P) 703-284-1610 (F) 703-284-3816

shealthc@marymount.edu

2807 N. Glebe Road

Arlington, VA 22207

**Consent for Medical Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am the parent/legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PARENT/LEGAL GUARDIAN NAME OF STUDENT currently a minor, whose date of birth is (m/d/y) \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ and is under the age of 18 years.

I authorize Marymount University Student Health Center (MUSHC) to provide medical care to my son/daughter, including, but not limited to: diagnostic examinations (including laboratory testing), tuberculosis screening, verification and/or administration of immunizations and any necessary medical treatment. This consent can be used for emergency transportation and emergency care, authorizing MUSHC to sign all necessary papers and arrange treatment in the event MUSHC is unable to reach me.

I further agree to release Marymount University, its employees, agents, officers, staff and physicians for all loss, damage, and injury (including death), whatsoever arising in connection with medical treatment provided by MUSHC or at MUSHC’s direction.

I understand that once my child reaches the age of majority, my consent for treatment is no longer required.

By signing, I acknowledge and agree that I have read and understood this consent, and any questions I have prior to signing may be answered by calling the Student Health Center at 703-284- 1610.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name Student ID #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

Phone(s) (*please include country code if needed)*:

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_