

EMBRY-RIDDLE AERONAUTICAL UNIVERSITY

Health Services Next Steps

WELCOME TO EMBRY-RIDDLE!

Your **Health Services Department** cares deeply about your well-being and is committed to providing you with health care and preventive education. All registered students, regardless of your insurance choice, will be seen and treated at Embry-Riddle's Health Services without a fee.

The Health Services staff will use your personal medical information for diagnosis, care, and consultation. The information you include in this record is confidential, as are all interactions with the staff.



CHECKLIST

SUBMIT THE COMPLETED MEDICAL FORM

Students must complete the Medical Report Form before registering for classes.

- ▶ Complete the personal data and medical history section.
- ▶ Complete and sign the Medical Form AND submit official copies of your immunization records. You may provide copies of laboratory reports indicating positive antibody titers for these diseases in lieu of immunizations.
- ▶ If you do not submit the required documentation, a Medical Hold will be applied to your account, which will prevent you from attending classes.
- ▶ Students not participating in the school health insurance plan - please provide a copy of your insurance card (front and back).

**You must still complete the online waiver to decline the school plan.*

UNDERSTAND THE REQUIRED IMMUNIZATIONS

Vaccinations for MMR (measles, mumps, rubella), Hepatitis B, and Meningitis are required. International students from TB endemic countries must also provide results of a recent Tuberculosis test or chest x-ray. BCG immunization does not apply.

SIGN UP FOR HEALTH INSURANCE

Embry-Riddle requires students to have health insurance. Students are automatically enrolled in the student health insurance plan, and the charge is added to your student account. Visit uhcsr.com to view plan benefits.

Students who are currently insured with comparable coverage can choose to decline and must do so during the waiver period in order to avoid premium charges.

Go to daytonabeach.erau.edu/health for further information. Contact our **Insurance Coordinator** at 386.226.6036 or creakn@erau.edu.



YOUR WELL-BEING

Your academic success is important to Embry-Riddle Aeronautical University, and we know that your overall well-being plays a vital role in your success. We provide you a variety of support services that can help you be the best you.



HEALTH SERVICES | 386.226.7917 ☎

The Health Services Department provides evaluation and treatment of illnesses, first aid, nutrition counseling, diagnostics services, annual exams, health education, medical support for flight students, and much more. The dedicated staff of full-time registered nurses, physician assistant, nurse practitioner, and physician are available to support you.



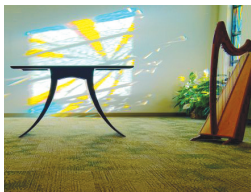
COUNSELING | 386.226.6035 ☎

The mission of the Counseling Center is simple: to enhance the psychological well-being of Embry-Riddle students. But the care, counseling, and education they provide is integral to help with coping, achievement of goals, stress, anxiety, depression, and other barriers to success. Counseling is confidential and offered free to our students.



DISABILITY SUPPORT SERVICES | 386.226.7916 ☎

We ensure equal access to resources and opportunities for all students, and we have a department specifically to guide and support students with disabilities. Disability Support Services facilitates and promotes the effective participation, academic persistence, and personal development of our students who need these services.



THE CENTER FOR FAITH AND SPIRITUALITY | 386.226.6580 ☎

The Center for Faith and Spirituality provides students of all beliefs and backgrounds a place to reflect and worship and encourages them in their lives of faith. The Center is home to the University Chaplains and religious clubs and organizations.



FITNESS CENTER | 386.323.8860 ☎

Work out, take classes, swim, and enjoy our fitness and athletic facilities. Take advantage of fitness classes, personal training, and all of the equipment needed to maintain a healthy, and fun, lifestyle.



WELLNESS PROGRAM | 386.226.7583 ☎

This initiative provides programs, incentives, and opportunities for students to further develop a healthier mind, body, and self-awareness. We focus on bringing out *the best in you*.



TOBACCO FREE | 386.226.7917 ☎

Embry-Riddle values health and wellness for our entire community. We are a tobacco-free campus and have been since 2013. We offer tobacco cessation programs at no cost for students. Visit Health Services or call with questions.

VISIT OUR WEBSITE FOR MORE INFORMATION:

► daytonabeach.erau.edu/health

EMBRY-RIDDLE
Aeronautical University™
DAYTONA BEACH, FLORIDA

Medical Report Form



Completion of this form is mandatory to meet ERAU health requirements and **must be returned** to Health Services prior to attending classes.

Embry-Riddle Health Services
600 S. Clyde Morris Blvd. Bldg. 500
Daytona Beach, FL 32114-3900

Phone: 386.226.7917 | Fax: 386.226.6082
Email: dbhealth@erau.edu
daytonabeach.erau.edu/health

▶ Student ID#: _____

▶ Email: _____ ▶ Cell Phone: _____

PERSONAL DATA -- *Please print legibly*

▶ Expected Semester of Entry: _____ Major: _____
MM YY

▶ Name: _____
Last First Middle

▶ Date of Birth: _____ Gender: _____ Height: _____ Weight: _____
MM DD YY

▶ Permanent Address: _____
No. & Street City State & Zip Code Country

▶ Emergency Contact: _____ Phone 1) _____ 2) _____

PERSONAL MEDICAL HISTORY

▶ Do you use any tobacco products or smoke any other substances? Yes or No

▶ Do you have any allergies? Please indicate (medications, insect stings, environmental factors, food):

▶ Please check if you are being treated or have been treated for any of the following and indicate the year. Attach a physician statement for any items checked, except chicken pox.

	Year		Year
<input type="checkbox"/> ADD/ADHD	_____	<input type="checkbox"/> Heart Murmur/Disease	_____
<input type="checkbox"/> Alcohol/Drug Dependency	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Anemia, Blood Disease	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Arthritis, Joint Disease, Bone Disease	_____	<input type="checkbox"/> Hypoglycemia	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Lyme Disease	_____
<input type="checkbox"/> Blood Clot/Phlebitis	_____	<input type="checkbox"/> Malaria	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Psychological Problems	_____
<input type="checkbox"/> Diabetes (indicate type)	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Digestive Disorders	_____	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Epilepsy, Seizures	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Head Injury	_____	<input type="checkbox"/> Other	_____

▶ Are you currently under the care of a physician for any other condition(s)? Please list and attach summary.

▶ List medications taken recently or currently (include birth control, vitamins and herbal preparations):

▶ List operations and/or hospitalizations (include reason and year):

Required Immunizations

ALL UNDERLINED TEXT IS CRITICAL TO ENROLLMENT. The immunization policy is designed to protect the health of all students.

▶ Name: _____ ▶ Date of Birth: _____
MM DD YY

MEDICAL HOLD TO STUDENT ACCOUNT

A medical hold will be applied to your account if we do not receive the appropriate documentation. Official copies of immunization records can be provided in lieu of a doctor's visit. Copies of school or military immunization records with appropriate information will also be accepted. Please attach to this form and return. Self-reports are not acceptable.

MMR (Measles/Mumps/Rubella): All students must provide proof of two doses given on, or after the first birthday. The second dose of MMR must be administered 28 days or more after the first dose. Students may provide copies of laboratory reports indicating positive antibody titers for these diseases in lieu of immunizations.

▶ 1st MMR: ____/____/____ ▶ 2nd MMR: ____/____/____

Hepatitis B and Meningococcal Meningitis: Please visit daytonabeach.erau.edu/health to learn about these diseases and their prevention through vaccination. All students must provide proof of immunizations for Hepatitis B and Meningococcal Meningitis OR complete the below section to decline.

▶ **Hepatitis B:** dose 1: ____/____/____ ▶ dose 2: ____/____/____ ▶ dose 3: ____/____/____

▶ **Meningococcal Meningitis:** ____/____/____ (If a primary dose was given before 16th birthday, a booster dose is recommended before entering college.) ____/____/____

▶ _____ ▶ Date: _____
Physician or Authorized Signature MM DD YY License # & Office Stamp with Address

WAIVER

I have read the detailed information provided at daytonabeach.erau.edu/health regarding the risks and dangers of contracting Hepatitis B and Meningitis. Embry-Riddle strongly encourages immunization.

I decline to receive Hepatitis B vaccines. _____
Student Signature Date

I decline to be vaccinated for Meningitis. _____
Student Signature Date

_____/_____/_____
Parent or Legal Guardian if Under 18 Date

▶ **Tuberculosis Test:** ____mm ____Pos ____Neg ____/____/____

REQUIRED ONLY FOR INTERNATIONAL STUDENTS FROM TUBERCULOSIS ENDEMIC AREAS. See details at daytonabeach.erau.edu/health. Results must be recent, within 3 months of entering classes. Physician's report of a current chest x-ray is acceptable. ****BCG IMMUNIZATION WILL NOT APPLY.**

▶ _____ ▶ Date: _____
Physician or Authorized Signature MM DD YY License # & Office Stamp with Address

▶ **Tetanus Immunization (Not Required):** Td/Tdap (most recent dose) dose ____/____/____

AUTHORIZATION FOR TREATMENT

I hereby grant permission to ERAU Health Services, Counseling Center staff, or the University Physician(s) to render any health care or emergency treatment to myself/son/daughter/ward. I also grant permission for the above referenced to arrange for health care, emergency treatment, or hospitalization or any other medical, psychological or dental care facility if necessary.

▶ _____ ▶ Date: _____ ▶ _____ ▶ Date: _____
Student Signature MM DD YY Parent or Legal Guardian if Under 18 MM DD YY