

MARIAN UNIVERSITY

Indianapolis

Dear student and parents,

Welcome to Marian University! We hope your time here is fulfilling and meaningful. You will be stretching outside your comfort zone and growing. To help you have a memorable and beneficial experience, the Health Center is available to you at **no charge**. Included with this letter are two forms: the **Student Health Record and the Immunization form**. Please complete and return these forms to: Director of Health Services; 3200 Cold Spring Road; Indianapolis, Indiana 46222. To help you complete the immunization form, we have listed below Indiana's vaccination requirements and recommendations.

Required Immunizations

1. Hepatitis B vaccine: 3 doses
2. Varicella vaccine (Chickenpox): 2 doses
3. Tetanus toxoid, reduced diphtheria toxoid and A-cellular pertussis vaccine (Tdap) : every 10 years
4. Tuberculin PPD test (Mantoux skin test): every 12 months. If you have been vaccinated with the BCG vaccine or had a positive mantoux test ,please submit a chest x-ray report
5. Measles, mumps, rubella vaccine (MMR): 2 doses
6. Polio vaccine: 3 doses
7. Meningococcal vaccine: 1 dose

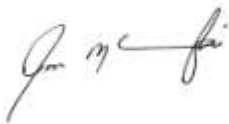
Recommended Immunizations

1. Hepatitis A vaccine
2. Gardasil vaccine

We offer the tuberculin PPD test (Mantoux test); tetanus toxoid, reduced diphtheria toxoid and A-cellular pertussis vaccine (Tdap) and annual influenza vaccinations for a fee. We administer other vaccines for a fee upon request.

We look forward to meeting you on campus. Please return the completed **Student Health Record Form with the Immunization Form** (with a copy of immunizations.)

Sincerely



Jan M. Carnaghi, APRN, FNP-BC
Director of Health Services
3200 Cold Spring Road
Indianapolis, Indiana 46222
Health Center line (317) 955-6154
Secured fax line: (317) 955-6133

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STUDENT HEALTH RECORD

Date this form completed: _____ Intended enrollment date: _____

Intended sport(s) if you are a student athlete _____

Print or type answers to all questions. The confidential information on this form is strictly for the Marian University Health Center / Marian Athletic Department (when applicable) and will not be released to anyone without written consent.

Personal Information

Name _____
Last First Middle

Home Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Date of Birth _____ Male Female

Physician Name _____ Phone (____) _____

Persons to Notify in Case of Emergency

Name #1 _____ Relationship _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Name #2 _____ Relationship _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Permission to Treat

I hereby authorize and give my consent to Marian University health care providers, personnel, and such Marian University designated health care representatives to examine and/or treat _____ for minor injury or illness. I also consent to any necessary health care treatment or first aid by appropriate Marian University personnel, and I further consent to such necessary health care treatment and medical procedures that may be deemed appropriate by a licensed physician in a medical facility. I also authorize to disclose necessary information to off campus health care providers as needed to treat an injury or illness.

Signature of student _____ Date _____

Signature of parent _____ Date _____

Insurance Information Student should have insurance card to bring to campus.

Policy Holder _____ Phone (____) _____

Insurance Company _____ ID # _____

Complete the Immunization Form with an attached copy of your immunizations, the Student Health Record Form and send to: Director of Health Services; Marian University; 3200 Cold Spring Road, Indianapolis, Indiana 46222-1997.

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Student Name: _____ **D.O.B.:** _____ **Allergies:** _____

Immunization Form:

Proof of immunization: One of the following (a copy- not the original) must be attached to this form.

* Personal record (i.e. vaccination booklet) * A physician or clinic report * School immunization

Required Immunizations:

Hepatitis B

Requires 3 vaccinations

#1 Date: _____

#2 Date: _____

#3 Date: _____

Varicella (Chickenpox)

Yes, I had chickenpox. Date: _____

No. If you have not had the Varicella disease you will need 2 vaccinations.

#1 Date: _____

#2 Date: _____

Tetanus-Diphtheria or Tdap

TD in the last 10 years. Date: _____

Tdap. Date: _____

Tuberculin PPD (within the last 12 months)

Mantoux Skin Test (PPD Test)

Date read: _____

Size in mm: _____

If you have had a positive PPD Test, a chest X-ray is required within the last 12 months.

Attach a copy of the X-ray report to the health form

MMR

All students born after 1956 should have 2 vaccinations of MMR.

Requires 2 vaccinations

#1 Date: _____

#2 Date: _____

Polio

Requires 3 vaccinations

#1 Date: _____

#2 Date: _____

#3 Date: _____

Meningitis Vaccine

Circle brand given:

Menactra; Menveo; Menomune;

other _____

Date: _____

Recommended Immunizations:

Hepatitis A

Requires 2 vaccinations

#1 Date: _____

#2 Date: _____

Gardasil

Requires 3 vaccinations

#1 Date: _____

#2 Date: _____

#3 Date: _____

All Students required to sign:

Student Signature (If student is 18 years or older)

Date Signed

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