MFA MEDICAL INFORMATION FORM

Columbus College of Art & Design

THIS FORM MUST BE RETURNED BY JULY 31 TO:

Student Affairs Office
Columbus College of Art & Design
60 Cleveland Ave.
Columbus, OH 43215
P: 614.222.4044
F: 614.222.4034

All students MUST SUBMIT this form and immunization records. Enrollment for next semester will not be permitted if you lack proof of mandatory vaccinations.

Please be aware that the college does not provide on-campus medical services. A physical examination, WHILE NOT MANDATORY, is highly recommended as a vital supplement to your health history.

Important: This form DOES NOT serve as official notification to the college of a disability for purposes of ADA or Section 504 of the Rehabilitation Act. If accommodations are requested, official documentation must be filed with Disability Services. Call 614.222.4004 for more information.

INSTRUCTIONS:

» The medical information forms (pages 1–3) are to be completed and signed by the student (or parent/guardian if student is under 18 years old).

» All immunizations (page 3) must be up to date and the form **signed by a health care professional**. Official print-outs from health care providers may be attached to the form in place of the signature.

» **If faxed from physician's office, please check that all mandatory immunizations as listed are current.**

» All information must be provided in English.

» Students seeking a medical/religious exemption to providing this information must contact the Student Affairs office at 614.222.4044.

» **Please make a copy of this record for your own files.** Medical forms will be held by CCAD for only 6 years from the date a student enters the college. After that, the medical form will be destroyed and no copies will be available.

STUDENT INFORMATION (PLEASE PRINT CLEARLY)

FULL LEGAL NAME _____

CITIZENSHIP _____ HOME ADDRESS _____

CITY /TOWN _____ STATE _____ ZIP _____

SEX _____ DATE OF BIRTH _____ HOME PHONE (_____) _____ CELL PHONE (_____) _____

EMAIL _____ SEMESTER ENTERING CCAD (FALL /SPRING; YEAR) _____

EMERGENCY CONTACT

NAME #1 _____ RELATIONSHIP TO STUDENT _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____ WORK PHONE (_____) _____

ADDRESS (IF DIFFERENT) _____ EMAIL _____

NAME #2 _____ RELATIONSHIP TO STUDENT _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____ WORK PHONE (_____) _____

ADDRESS (IF DIFFERENT) _____

EMAIL _____

MEDICAL INFORMATION FORM (CONTINUED)

Columbus College of Art & Design

PERSONAL HEALTH HISTORY

To be completed by student and reviewed by health care provider. All information included in this form is considered confidential and will only be shared with appropriate administrators or health care professionals in the event of a health or safety emergency.

Question	Yes	No	If you selected "yes," please provide details.
Are you being treated for any medical condition that requires specialty care or regular visits to a physician?			
Do you have allergies to food, insect bites/stings, or any other materials or substances?			
Are you allergic to any medicine? If yes, please list medicine and allergic symptom.			
Do you have any physical limitation(s) that would require assistance in the event of an emergency evacuation of a classroom, residence hall, or other space?			
Have you had any major surgery (for example, tonsillectomy, appendectomy, hernia repair)?			
Are there any other known conditions that could present a risk to yourself or others?			

PHYSICAL EXAMINATION

A physical examination, **while not mandatory**, is highly recommended as a vital supplement to your health history. We find that a physical exam prior to the beginning of classes can help ensure a semester uninterrupted by absences due to illness. Including a copy of your physical examination report when you return these health documents is helpful to the college in the event of an emergency or other medical situation.

I GIVE PERMISSION FOR HEALTH CARE PROVIDERS TO ADMINISTER ANY MEDICAL OR DENTAL PROCEDURES THAT ARE NECESSARY IN AN EMERGENCY.

SIGNATURE OF STUDENT _____ DATE _____

PRIMARY HEALTH CARE PROVIDER

PRIMARY HEALTH CARE PROVIDER NAME _____ TITLE _____

ADDRESS _____ PHONE (_____) _____

PRIMARY HEALTH INSURANCE COMPANY _____ MEMBER'S NAME _____

CARD/GROUP _____ PHONE (_____) _____

MEDICAL INFORMATION FORM (CONTINUED)

Columbus College of Art & Design

IMMUNIZATION RECORD (MANDATORY)

Please read this form carefully and pay attention to what is required verses what is optional.

CCAD requires all students to show proof of vaccination against Measles, Mumps, and Rubella (MMR), Hepatitis B, and Meningococcal Meningitis. (Meningococcal meningitis vaccine is required if you will be living on-campus in a residence hall. Commuter students may opt to sign the waiver below.) If none of the Hepatitis B series shots have been received prior to entering school, documentation of the first injection along with the dates of your appointments for the second and third must be submitted with this form. If documentation is not available for any vaccinations, you will need to have titer levels checked with your doctor and provide that documentation. These requirements, although time consuming, are necessary for everyone's protection. If faxed from your physician's office, please check that all mandatory immunizations as listed below are current.

Please do not wait until the last minute to schedule your necessary vaccinations.
You will not be permitted to enroll for the next semester if you lack proof of mandatory vaccinations.

MAKE A COPY OF THIS PAGE FOR YOUR OWN RECORDS. CCAD will only maintain this record for 6 years from the time a student enters the college. After that, it will be destroyed.

MANDATORY IMMUNIZATIONS

MEASLES/MUMPS/RUBELLA (MMR) (MM/DD/YY) DOSE #1: _____ DOSE #2: _____

HEPATITIS B (MM/DD/YY) DOSE #1: _____ DOSE #2: _____ DOSE #3: _____
Please note only the first dose for Hepatitis B is required

MENINGOCOCCAL MENINGITIS VACCINE (MM/DD/YY) _____
Required for any student who lives on campus.

☐ I choose to waive the meningitis vaccine and will NOT be living on campus.
Note: Only Commuter students may waive the meningitis vaccine

_____ _____
SIGNATURE OF STUDENT DATE (MM/DD/YY)

RECOMMENDED IMMUNIZATIONS

TETANUS/DIPHTHERIA (WITHIN LAST 5 YEARS) (MM/DD/YY)_____

MANTOUX TEST FOR TB

DATE OF TEST (MM/DD/YY) _____

DATE OF READING (MM/DD/YY) _____

CHECK ONE: ____ NEG ____ POS ____ MM INDURATION

IF TB TEST IS POSITIVE: CHEST X-RAY REPORT (CHECK ONE): ____ NEG ____ POS DATE (MM/DD/YY) _____

IF CHEST X-RAY IS POSITIVE EXPLAIN TREATMENT: _____

_____

SIGNATURE OF HEALTH CARE PROVIDER (REQUIRED)

OFFICIAL PRINT-OUTS FROM HEALTH CARE PROVIDERS MAY BE SUBMITTED ATTACHED TO THIS FORM IN PLACE OF THE SIGNATURE BELOW.

SIGNATURE OF DOCTOR (OR OTHER PROFESSIONAL HEALTH CARE PROVIDER) _____

ADDRESS _____

PRINTED DOCTOR'S NAME_____ DATE _____