

FONTBONNE UNIVERSITY HOUSING APPLICATION
RESIDENTIAL STUDENT HEALTH MEDICAL INFORMATION

NAME _____ ID# (if known) _____ Semester/Year _____

SCREENING AND IMMUNIZATION REQUIREMENTS

ALL FIRST TIME resident and international students must have the following screening and immunizations. If you fail to satisfy this requirement you will not be able to check in to university housing. All resident students must have a completed medical history form. This will become part of a confidential record while at Fontbonne University and will be kept in their personal health folder.

REQUIRED IMMUNIZATIONS

- **Tuberculin Screening must be no older than six (6) months prior to moving into university housing. Screening tests received outside of the United States will not be accepted.**
- **Meningococcal vaccine** for meningitis, good for 5-10 years
- **Mumps is required;** Childhood combination of Mumps, Measles, Rubella (MMR) is acceptable.

INTERNATIONAL STUDENTS: Tuberculosis screening tests received out of the United States will not be accepted. Incoming international students must provide evidence that they are free of tuberculosis with a screening. International resident students must adhere to the requirements above to include mumps and meningitis immunization records.

All resident students: If our office is notified that a resident student has a positive tuberculosis screening, additional medical attention is required. This additional medical attention is necessary and requires a chest x-ray. It is the resident student's responsibility to provide the university with written documentation that this x-ray and follow up medical attention has been received.

The following are recommended immunizations but not required: Hepatitis A and B, Tetanus/Diphtheria (TD), and varicella (chicken pox).

All resident students are required to attach a copy of the Immunization documentation from a clinic or physician's office to this form and turn it into the Residential Life office by **AUGUST 1 for fall semester residents; JANUARY 1 for spring semester residents.** For questions, email reslife@fontbonne.edu

Please complete and return this form with the photo copy of insurance card and Immunization documentation either by email reslife@fontbonne.edu , or by mail to:

Fontbonne University
Department of Residential Life
6800 Wydown Blvd.
St. Louis, MO 63105

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RESIDENTIAL STUDENT HEALTH MEDICAL INFORMATION

Name _____ ID or SSN# _____

Home Address _____

Home Phone _____ Marital Status: S M D W

Present Age _____ D.O.B. _____ Place of Birth _____

Parent, Guardian, or Other Name _____

Full Address (if different from above) _____

Cell or Business Phone _____ Home Phone _____

Physician's Name and Phone Number _____

INSURANCE INFORMATION

Are you covered by hospitalization insurance? (Check the age limit for dependents on your policy) Yes No

If yes, name of insurance company _____

Attach a photo copy of the insurance card

Name of subscriber _____ Policy Number _____

MEDICAL HISTORY

Are you allergic to any medication? Yes No If yes, please list. _____

Please list any medication or special forms of therapy you need regularly or any additional information that may be helpful for your medical well-being. _____

Are you currently being treated for any condition? Yes No If yes, please explain. _____

Describe any serious illness, injury, or operation you have had, give the nature of the condition, date, hospital name and location. Are there any persistent after effects? _____

OPERATIVE PERMIT

The law requires that parental permission be obtained for operative procedures on minors. The following consent form should be signed by the parent or guardian of the minor so that in the event of an emergency, medical procedures may be promptly carried out, and so that no unnecessary delays will occur with less urgent operative procedures. **However, no operation other than minor office procedures will be performed, except in cases of extreme emergency, without the parent or guardian being contacted and fully informed.**

I give permission for such operative procedures as may be deemed necessary for my son/daughter/ward.

Signature _____ Relationship _____ Date _____