Health Record Checklist

Read Carefully!

Read Carefully!

Congratulations on your acceptance to The University of Virginia's College at Wise. Prior to your enrollment we need information about your health status. Below is a checklist of items that **must be** **turned in to the Health Services Office before August 1st for the Fall semester and January 2nd for the Spring semester per State and University requirements:**

_____ Pre-Entrance Health Record **completed** and **signed** (attached)

_____ Copy of the front and back of insurance card. All students are required to have health insurance.

_____ Childhood immunization record which includes two doses of MMR (measles, mumps, or rubella vaccine)

_____ Tetanus booster within the last 10 years

_____ TB screening or skin test on or after March 1, 2006 (Please see attached form.)

_____ Meningitis vaccination or a signed waiver form (attached)

_____ Hepatitis B vaccination or a signed waiver form (attached)

_____ The signature of a licensed health care provider is required for all immunizations or a copy of the record. Must be provided.

Students will not be allowed to register for classes for the next semester if this information is not provided.

ALL HEALTH RECORDS MUST BE RETURNED TO THE FOLLOWING ADDRESS. DO NOT SEND THEM TO ANY OTHER OFFICE. We will not be responsible for any records that do not reach our office. It is your responsibility to make sure that we have received your records before the deadline. We recommend that you make a copy of everything before you send it.

The Center for Student Development
The University of Virginia's College at Wise
One College Avenue
Wise, VA 24293
Telephone: (276) 376-1005 or 328-0193
Fax: (276) 376-1056

THE UNIVERSITY OF VIRGINIA'S COLLEGE AT WISE

HEALTH SERVICES — THE CENTER FOR STUDENT DEVELOPMENT — (276) 328-0193

PRE-ENTRANCE HEALTH RECORD

TO THE STUDENT: Please print or type in black ink, answering all questions. This information will become part of your confidential health record accessible only to appropriate College personnel. **Return this form no later than August 1 for fall semester (January 2 for spring semester) to The Center for Student Development, UVa-Wise, 1 College Avenue, Wise, Virginia 24293. Failure to complete this form will prevent you from registering for classes. Forms must only be returned to the above address.**

1. PERSONAL DATA

Name ______________________________________ Social Security Number ______ - ______ - ________
Last First Middle

Home Address ____

____
City State Zip

Telephone ( ) _______ - ___________ Sex (circle one): M F Birthdate ______ / ______ / ______
Month Day Year

2. EMERGENCY CONTACT(S)

Name ______________________________________ Relationship ______________________________
Last First

Home Address ____

____
City State Zip

Home telephone ( ) _______ - ___________ Work telephone ( ) _______ - ___________

Name ______________________________________ Relationship ______________________________
Last First

Home Address ____

____
City State Zip

Home telephone ( ) _______ - ___________ Work telephone ( ) _______ - ___________

3. CURRENT HEALTH INFORMATION

Do you have allergies? ❑ Yes* ❑ No
**Check the boxes below to indicate the type of allergies and specify type.*

❑ **Medications** ______________________________ ❑ **Insect venom** ______________________________
specify drug specify insect

❑ **Foods** ______________________________ ❑ **Pollens, dusts, molds** ______________________________
specify food specify type

❑ **Other** ______________________________ ❑ **Other** ______________________________
specify specify

Are you taking any medications? ❑ Yes* ❑ No
**List medications (including birth control pills, allergy, acne drugs, etc.), doses, and reason for taking them below.*

______________________ ______________________ ______________________
drug dose reason drug dose reason drug dose reason

______________________ ______________________ ______________________
drug dose reason drug dose reason drug dose reason

4. HEALTH HISTORY

Do you have any current, recent or past health problems, hospitalizations, surgeries, or injuries? ❑ Yes* ❑ No
**Please provide additional information below.*

____

____

____

5. MENTAL HEALTH HISTORY

Please answer all questions. Additional information (medications, reason for medication, dates, place and duration of treatment, etc.) must be provided for any questions answered "yes."

Has your academic and/or work activities ever been interrupted because of mental or emotional problems? ❑ Yes ❑ No
____

Have you ever been treated with any medication for psychiatric reasons? ❑ Yes ❑ No
____

Have you ever been hospitalized for mental or emotional problems? ❑ Yes ❑ No
____

6. IMMUNIZATION/SCREENING REQUIREMENTS

(Required by law.)

The signature of your health care professional must accompany this information. Please complete entire section or send documentation from your health care professional. ***Failure to complete this information will prevent you from registering for classes.***

Childhood Immunizations

DPT Series (Diphtheria, Pertussis, Tetanus)
Dates received: 1st.________________2nd.________________3rd.__________________Booster______________________

IPV/OPV (Polio) Series
Dates received: 1st._______________2nd.________________3rd.__________________Booster_______________________

MMR (Measles, Mumps, Rubella)
Dates received: 1st.______________2nd.__________________Must have received two doses if born after 1957.

Immunization Boosters Required

Tetanus (within 10 years prior to registration)
Date received:______________________________

PPD/TB Test or Screening (Must be completed on or after March 1, 2006. Please see the Tuberculosis Screening Form that is attached.)
Date performed:____________________________
Results: Negative________ Positive*_______ **If positive a chest x-ray is required.*

Meningitis (Meningococcal) Vaccine: The risk of meningitis and meningococcal infection may be increased in some subsets of college students. The American College Association recommends you receive this vaccination. In accordance with Virginia State Law, students who do not receive this vaccination must sign a waiver. Date received _____________________________________

Hepatitis B Vaccination: In accordance with Virginia State Law, students who do not receive this vaccination must sign a waiver.
Dose #1____________________ Dose #2 ________________ Dose #3_________________

Health Professional Signature ____ **Date** _____ / _____ / _____

7. IMMUNIZATIONS RECOMMENDED BUT NOT REQUIRED

Based on guidelines from the American College Health Association (ACHA), the following immunization is also recommended, but are not required. Please consult your personal physician if you have any questions about these immunizations.

Varicella (chicken pox) Diagnosis of disease: _______ Yes _______ No Vaccine date ___________________________

Health Professional Signature ____ **Date** _____ / _____ / _____

8. INSURANCE INFORMATION

All students are required to have health insurance. ***A copy of the front and back of your insurance card must be provided. If you do not have a card, a copy of your policy must be provided.*** ***Failure to complete this information will prevent you from registering for classes.***

Name of Insurance Company ____

Street Address ____

City ____ State ________________________ Zip ________________

Insurance Company's Telephone Number ( ) _________ - _______________ Policy Number ______________________________

Cardholder's Name_______________________________________ Cardholder's Employer ______________________________

Cardholder's Social Security Number________ - ________ - _________ Insurance Group Number __________________________

I hereby assign the benefits of my insurance policy to The University of Virginia's College at Wise designated health care provider, as appropriate. I understand that I am responsible for all charges that are not paid by that policy. I authorize the release of information needed to my insurance company in order to consider payment of my claim for services rendered.

I understand that this assignment and authorization will remain in effect indefinitely or until such time that I give written notice to the contrary.

_______ / _______ / _______ ____
Date Signature of Policy Holder

Your signature below indicates that the information you provided on this form is accurate and complete and that all immunizations and required tests have been correctly and truthfully recorded. Your signature also gives permission for the release of medical information to appropriate College personnel.

____ _______ / _______ / _______
Student signature (full name) Month Day Year

____ _______ / _______ / _______
Parent/guardian signature of a minor student (full name) Month Day Year

The University of Virginia's College at Wise

Health Services The Center For Student Development (276) 328-0193

TUBERCULOSIS SCREENING

(required of all students)

Name ______________________________ SSN ___________________________

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

The American College Health Association has published new guidelines on tuberculosis screening of college and university students. The University of Virginia's College at Wise has adopted these guidelines based on recommendations from Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/pubs/corecurr/.

1. Does the student have signs or symptoms of active TB disease? YES NO
   If NO, proceed to question 2.
   If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group or is the student entering the health professions? (see footnote #1 below) YES NO
   If NO, stop. No further evaluation is needed at this time.
   If YES, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified Protein derivative [PPD] tuberculin containing 5 Tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk Group. If PPD is not placed, a chest x-ray is required (see #4 to record x-ray result).

3. Tuberculin Skin Test (must have been placed on or after March 1, 2006)
   Date given: ___________ Date read: ___________
   Result: ___________ (Record actual mm of induration, transverse diameter; if no induration, write "0").
   Interpretation (based on mm of induration as well as risk factors): Positive
   Negative

4. Chest X-Ray (required if tuberculin skin test is positive or if PPD has not been placed for any reason; must have been performed on or after March 1, 2006):
   Result: Normal Abnormal Date of chest x-ray: _________________

[1]Categories of high-risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resident in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gasterectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone greater than or equal to 15 mg/d for greater than or equal to 1 month) or other immunosuppressive disorders.

HEALTH CARE PROVIDER:

Name: ________________________________ Address: ________________________________

Signature: ________________________________ Phone: ____________________________

THE UNIVERSITY OF VIRGINIA'S COLLEGE AT WISE

HEALTH SERVICES THE CENTER FOR STUDENT DEVELOPMENT (276) 328-0193

RELEASE OF MEDICAL INFORMATION
TO
APPROPRIATE COLLEGE PERSONNEL

As a student of The University of Virginia's College at Wise, I realize that it is possible for a medical emergency to occur. Therefore, I am giving the nurse or her designee in Health Services permission to release the medical information listed below to the appropriate officials (i.e. Residence Life Staff, Campus Police). I understand that my records will be kept confidential at all times by these officials.

____ ____
Name of Student Signature of Student

____ ____
Signature of Parent (if a minor) Date

Please list medical conditions and/or allergies. Be sure to list any medications that you are allergic to (do not list medications that you are currently taking):

____

____

Please list medications that you are currently taking.

____

____

- -

PARENTAL CONSENT FORM FOR MINOR STUDENT

I, the parent/legal guardian of ___________________________________ (enter student's full name), give permission for The Center for Student Development personnel at The University of Virginia's College at Wise*, the physician at the College's designated health care provider's** clinic or their designee, and/or College's designated health care provider's Hospital Emergency Department personnel to provide medical assistance to my son/daughter who is under 18 years of age, and is therefore legally a minor.

_________________________ ____ ____ / ____ / ____
Relationship to student Signature of parent/legal guardian Today's date

____
Full name of parent/legal guardian

____
Street Address/Post Office Box

____
City State Zip

( ) ______________________ ( ) ______________________
Home telephone number Work telephone number

*The Center for Student Development may provide medical assistance; provide over-the-counter medication and/or personal counseling by a registered nurse and/or a professional counselor.

**Norton Community Hospital is UVa-Wise's health care provider.

THE UNIVERSITY OF VIRGINIA'S COLLEGE AT WISE

HEALTH SERVICES THE CENTER FOR STUDENT DEVELOPMENT (276) 328-0193

Waiver of Immunization Against Hepatitis B

The Code of Virginia (Chapter 340 23-7.5) requires that "All full time students, prior to enrollment in any public four year institution of higher education, shall be vaccinated against Hepatitis B." Institutions of higher education must provide the student or the student's parent or other legal representative detailed information on the risks associated with the Hepatitis B, and on the availability and effectiveness of any vaccine. The Code permits "the student or if the student is a minor, the student's parent or the legal representative to sign a written waiver stating that he/she has received and reviewed the information on Hepatitis B and detailed information on the risks associated with the Hepatitis B and on the availability and the effectiveness of any vaccine, and has chosen not to be or not to have the student vaccinated."

I have read the Hepatitis B Frequently Asked Questions at http://www.cdc.gov/ncidod/diseases/hepatitis/b/faqb.htm, and reviewed the risks associated with the disease, including the effectiveness and availability of any vaccine against Hepatitis B.

I choose not to be vaccinated against Hepatitis B.

____
Name (Please Print)

____
Student Social Security Number

____
Student Date of Birth

____
Signature of Student or Parent or Legal Representative if the student is a minor — Date

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Waiver of Immunization Against Meningococcal Disease

The Code of Virginia (Chapter 340 23-7.5) requires that "All full time students, prior to enrollment in any public four year institution of higher education, shall be vaccinated against Meningococcal Disease." Institutions of higher education must provide the student or the student's parent or other legal representative detailed information on the risks associated with the Meningococcal Disease, and on the availability and effectiveness of any vaccine. The Code permits "the student or if the student is a minor, the student's parent or the legal representative to sign a written waiver stating that he/she has received and reviewed the information on Meningococcal Disease and detailed information on the risks associated with Meningococcal Disease and on the availability and effectiveness of any vaccine, and has chosen not to be or not to have the student vaccinated."

I have read the Meningococcal Disease Frequently Asked Questions at http://www.acha.org/projects_programs/faq.cfm, and reviewed the risks associated with the disease, including effectiveness and availability of any vaccine against Meningococcal Disease.

I choose not to be vaccinated against Meningococcal Disease.

____
Name (Please Print)

____
Student Social Security Number

____
Student Date of Birth

____
Signature of Student or Parent or Legal Representative if the student is a minor — Date