

**THE UNIVERSITY OF VIRGINIA'S
COLLEGE AT WISE**



PRE-ENTRANCE HEALTH PACKET

FALL 2010-SPRING 2011

This health information is required of all new students.

PRE-ENTRANCE HEALTH PACKET CHECKLIST

Congratulations on your acceptance to The University of Virginia's College at Wise. Prior to your enrollment, information about your health and immunization status is required by Virginia law and College policy to be submitted to Health Services in the UVa-Wise Center for Student Development.

Please use the checklist below to ensure that all necessary items for your Pre-Entrance Health Packet have been completed and are included. Your completed Pre-Entrance Health Packet must be submitted to Health Services in the UVa-Wise Center for Student Development by 5 pm on August 1st for students entering in the fall semester and by 5 pm on January 2nd for students entering in the spring semester.

- Complete *Pre-Entrance Health Record* (pp. 1-2), including:
 - up-to-date immunization/screening information, including:
 - ▶ records and appropriate boosters for required childhood immunizations, including two (2) does of MMR (measles, mumps and rubella), a tetanus booster within the past ten (10) years, and a TB screening or skin test (p. 3) on or after March 1, 2010
 - ▶ records (or appropriate waiver forms, p. 5) for required additional immunizations and screenings for both Hepatitis B and Meningococcal Disease
 - ▶ immunization record for ACHA-recommended Varicella (chicken pox) vaccine, if received
 - ▶ signature of health professional
 - full insurance information, including signature of policyholder/carrier (p. 2)
 - student signature
 - legal guardian signature for minor students
- Complete *Release of Medical Information Form* (p. 4)
- Complete *Medical Consent for Minor Students Form* (p. 4), if applicable
- Provide proof of insurance. All students are required to have health insurance and must provide complete insurance information (p. 2) AND a copy of the card (front/back).
- Retain a copy of the Pre-Entrance Health Packet for your records.

Failure to return the completed Pre-Entrance Health Packet will prevent a student from registering for classes.

Please return the completed Packet to the address or fax number below. Please do not enclose it with other College correspondence to ensure that it reaches Health Services in a timely manner. For additional information or if you have questions, please contact us at (276) 376-1005.

The Center for Student Development
The University of Virginia's College at Wise
One College Avenue
Wise, VA 24293
FAX (276) 376-1056



PRE-ENTRANCE HEALTH RECORD 2010-2011

CENTER FOR STUDENT DEVELOPMENT
The University of Virginia's College at Wise
One College Avenue • Wise, VA 24293-4412

PHONE (276) 376-1005
FAX (276) 376-1056
WEB www.uvawise.edu

Students: Please answer ALL questions (type or black ink only). This information will become part of your confidential health record accessible only to appropriate College personnel. Failure to complete and return this form to the above address by August 1 for fall semester (January 2 for spring semester entry) will prevent registration for classes.

PERSONAL DATA

Name _____ SSN XXX - XX - _____
Last First M. I. (last four digits only)

Home address _____
PO Box/Street Address
City State Zip code

Telephone () _____ home; () _____ cell Birthdate ____ / ____ / ____ Sex Male Female

EMERGENCY CONTACTS

Please include at least one contact who does not live at your permanent residence.

1. Name _____ Relationship _____
Last First

Home address _____
PO Box/Street Address
City State Zip code

Telephone () _____ home; () _____ work; () _____ cell

2. Name _____ Relationship _____
Last First

Home address _____
PO Box/Street Address
City State Zip code

Telephone () _____ home; () _____ work; () _____ cell

CURRENT HEALTH INFORMATION

Do you have any allergies? No Yes, please check applicable boxes below & specify in the space provided.

- Medications _____ Insect venom _____
- Foods _____ Pollens/dusts/molds _____
- Other _____

Are you currently taking any medications (birth control, allergy, acne, etc.)? No Yes, please detail below.

- Drug _____ / dose _____ / reason _____
- Drug _____ / dose _____ / reason _____
- Drug _____ / dose _____ / reason _____
- Drug _____ / dose _____ / reason _____
- Drug _____ / dose _____ / reason _____
- Drug _____ / dose _____ / reason _____

Do you have any current, recent or past health problems, hospitalizations, surgeries, or injuries? No Yes, please detail below.

MENTAL HEALTH HISTORY

Please answer all questions. If "yes," additional information required (medications, reasons for medication, dates, place/duration of treatment, etc.).

Have your academic and/or work activities ever been interrupted because of mental or emotional problems? No Yes, explain.

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Have you ever been treated with any medication for psychiatric reasons? No Yes, explain. _____

Have you ever been hospitalized for mental or emotional problems? No Yes, explain. _____

IMMUNIZATIONS/SCREENINGS

The immunizations/screenings listed below are required by Virginia law. The signature of your health care professional must accompany this information.

Please check the appropriate box (check only one):

- A copy of immunization/screening documentation with signature of my health care professional is attached; enclosed Tuberculosis Screening Form required. *Please proceed to Insurance Information section.*
- Outlined below is my immunization/screening documentation, including the signature of my health care professional.

Required childhood immunizations

DPT (Diphtheria/Pertussis/Tetanus) Series

Dates received: 1st _____; 2nd _____; 3rd _____; Booster _____

IPV/OPV (Polio) Series

Dates received: 1st _____; 2nd _____; 3rd _____; Booster _____

MMR (Measles/Mumps/Rubella) Series

Dates received: 1st _____; 2nd _____ *Must have received two doses if born after 1957.*

Other required immunizations & screenings

Tetanus *Must have been received within 10 years of registration.*

Date received: _____

PPD/TB Test or Screening *Must be completed on or after March 1, 2010.*

Screening date: _____ Results: No test required; form required Test required

Test date: _____ Results: Negative Positive - chest x-ray required

Meningococcal (Meningitis) Vaccine *The risk of meningococcal disease may be increased in some subsets of college students. The American College Association recommends you receive this vaccination. In accordance with Virginia law, students who do not receive this vaccination are required to complete the enclosed waiver.*

Date received: _____ Not received: Completed waiver enclosed

Hepatitis B Vaccine *In accordance with Virginia law, students who do not receive this vaccination are required to complete the enclosed waiver.*

Date received: _____ Not received: Completed waiver enclosed

Recommended immunization

Varicella (Chicken Pox) Vaccine *Based on guidelines from the American College Health Association (ACHA), this immunization is recommended but not required. Consult your health care professional with questions.*

Varicella diagnosis: Date _____ OR Vaccine: Date rec'd _____ Not taken

Required signature Health Professional Signature _____ Date _____

INSURANCE INFORMATION

All students are required to have health insurance – full information below and a copy of the card (front/back) must be on file.

Insurance Company: Name _____ Policy Number _____
Address _____ Group Number _____
City/State Zip _____ Telephone Number _____

Policyholder: Name _____ Employer _____
Social Security Number _____ Required copy of card front/back enclosed

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.

Policyholder signature _____ Date _____

STUDENT and/or PARENT/GUARDIAN SIGNATURE(S)

My signature below indicates that the information provided on this form is accurate and complete, and that all immunizations and required screenings/tests have been correctly and truthfully recorded. I also understand that my signature signifies permission for the release of medical information to appropriate College personnel.

Student signature (full name) _____ Date _____

Parent/guardian signature of a minor student (full name) _____ Date _____



TUBERCULOSIS SCREENING FORM 2010-2011

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A record of a Tuberculosis Screening is required for all students enrolled at The University of Virginia's College at Wise. Students may submit the information in one of two ways: 1. submit this form which has been completed and signed by your health care professional OR 2. have your health care professional complete and sign the appropriate section on the College's Pre-Entrance Health Form.

Name _____ SSN XXX-XX-_____
Last First M. I. (last four digits only)

*****THIS SECTION TO BE COMPLETED BY YOUR HEALTH CARE PROFESSIONAL*****

The American College Health Association has published 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 the Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org, www.cdc.gov/tb/default.htm or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments. Please complete this form for the student designated above:

- Does the student have signs or symptoms of active TB disease?
 - NO...proceed to question 2
 - YES...proceed with additional evaluation to exclude active TB disease, including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
- Is the student a member of a high-risk group¹ (see below) or is the student entering the health profession?
 - NO...stop, no further evaluation is needed at this time; screening is complete.
 - 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 results).
- Tuberculin Skin Test (must have been placed on or after March 1, 2010)

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): negative positive
- 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, 2010)

Date of x-ray: _____ Result: normal abnormal

Health Care Professional:

Name _____ Address _____
Telephone _____
Signature _____ Date _____

¹Categories of high-risk students include those students who have arrived within the past five (5) years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, student 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, gastrectomy 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 one month) or other immunosuppressive disorders.



MEDICAL CONSENT FORMS

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RELEASE OF MEDICAL INFORMATION

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 Health Services nurse or his/her designee permission to release the medical information listed below to the appropriate officials (i.e. Residence Life staff and Campus Police). I understand that my records will be kept confidential at all times by these officials.

Please list medical conditions and/or allergies, including medication allergies: _____

Please list medications that you are currently taking: _____

Student name _____ & signature _____ Date _____

Parent/legal guardian signature of minor student _____ Date _____

MEDICAL CONSENT FOR MINOR STUDENTS

I, the parent/legal guardian of _____ (full student name), give permission for The Center for Student Development personnel of The University of Virginia's College at Wise¹, the physician at the College's designated health care provider² clinic or his/her designee, and/or the Emergency Department personnel of College's designated health care provider² to provide medical assistance to my son/daughter who is under 18 years of age, and is therefore legally a minor. I also give you permission of contact the person listed below in the event that I cannot be reached.

Full name of parent/legal guardian _____ Relationship to student _____

Street Address/PO Box _____

City _____ State _____ Zip _____ Telephone (h) _____ / (w) _____

Parent/legal guardian signature _____ Date _____

Emergency contact in the event parent/legal guardian noted above cannot be reached:

Full name _____ Relationship to student _____

Street Address/PO Box _____

City _____ State _____ Zip _____ Telephone (h) _____ / (w) _____

¹The 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.

²Norton Community Hospital of Mountain States Health Alliance is the current UVa-Wise contracted health provider.



HEPATITIS B & MENINGOCOCCAL IMMUNIZATION WAIVER FORMS

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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 have the student vaccinated.”

I have read the Hepatitis B Frequently Asked Questions at 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.

Student name _____ & signature _____ Date _____

Student date of birth _____ Student social security number (last 4 digits only) XXX - XX - _____

Parent/legal guardian signature of minor student _____ Date _____

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 the Meningococcal Disease and on the availability and the effectiveness of any vaccine, and has chosen not to be or not have the student vaccinated.”

I have read the Meningococcal Disease Frequently Asked Questions at www.cdc.gov/meningitis/about/faq.html, and reviewed the risks associated with the disease, including the effectiveness and availability of any vaccine against Meningococcal Disease.

I choose not to be vaccinated against Meningococcal Disease.

Student name _____ & signature _____ Date _____

Student date of birth _____ Student social security number (last 4 digits only) XXX - XX - _____

Parent/legal guardian signature of minor student _____ Date _____



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