UVA Wise
Pre-Entrance Health Packet

This health information is required of all students.

Failure to return this completed packet will prevent a student from registering for classes and accessing grades.

STUDENT-ATHLETES: This packet also contains REQUIRED Student-Athlete forms.

Failure to return these forms will prevent a student-athlete from participating in ALL athletic activities.

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 UVA Student and Employee Health Wise.

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 UVA Student and Employee Health Wise by 5 pm on August 1 for students entering in the fall semester and by 5 pm on January 2 for students entering in the spring semester.

ALL STUDENTS, INCLUDING STUDENT-ATHLETES:

- ☐ Complete the ***Pre-Entrance Health Record*** (pp. 1-4), including:
  - general and current health information (p. 1-2)
  - release of medical information and/or medical consent for minor students (p. 2)
  - up-to-date immunization/screening information with signature of health professional (pp. 3-4)
  - full insurance information, including signature of policyholder/carrier AND copy of card (front/back) (p. 4)
  - student signature (p. 4)
  - legal guardian signature for minor students (p. 4)
- ☐ Records (or appropriate waiver forms, p. 5) for required additional immunizations and screenings for both Hepatitis B and Meningococcal Disease
- ☐ Retain a copy of all forms for your records.

STUDENT-ATHLETES ONLY

In addition to the Pre-Entrance Health Packet, student-athletes must also:

- ☐ Complete the ***Athletics Medical History Form*** (p. 6)
- ☐ Complete the ***Athletics Pre-Participation Physical Evaluation*** (p. 7)
- ☐ Retain a copy of all forms for your records.

NOTE: Look for additional athletics forms via email through ARMS from the Athletic Training Department.

Please return the completed Packet (AND, if a student-athlete, the Student-Athlete Participation forms) to Health Services at 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.

UVA Student & Employee Health Wise
1 College Avenue
Wise, VA 24293
Fax: 276-328-3102
Email: healthclinic@uvawise.edu

PRE-ENTRANCE HEALTH RECORD

UVA Student & Employee Health Wise
The University of Virginia's College at Wise
1 College Avenue ◆ Wise, VA 24293-4412

PHONE 276-376-3475
FAX 276-328-3102

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) 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 medications, 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.
____

Have you ever been treated with any medications for psychiatric reasons? ❑ No ❑ Yes, explain. ____________________________
____

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

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 of minor student:
Name ______________________________ Signature ____________________________ 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 Wise[1], the physician at the College's designated health care provider[2] clinic or his/her designee, and/or the Emergency Department personnel of College's designated health care provider[1] 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) _____________

[1]The Center for Student Development may provide medical assistance, over-the-counter medication and/or personal counselor by a registered nurse and/or a licensed professional counselor. [2]Norton Community Hospital of Mountain States Health Alliance is the current UVa-Wise contracted health provider.

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

IMMUNIZATIONS / SCREENINGS

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

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. have your health care professional complete and sign the appropriate section in "Other required immunizations & screenings" below OR 2. have your health care professional complete and sign the "Tuberculosis Screening" section below.

Please check the appropriate ONE box only:

❑ A copy of immunization/screening documentation with signature of my health care professional is attached; *Tuberculosis Screening* section must be completed by heath care professional.

❑ Outlined below is my immunization/screening documentation; if TB test or screening listed was not completed within six months of enrollment, *Tuberculosis Screening* section must be completed by health care professional.

Required childhood immunizations

DPT (Diptheria/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 received **within 10 years of enrollment**.*
Dates received: ____________

PPD/TB Test or Screening *Must be completed within six months prior to enrollment.*
Screening date: ____________ **Results:** ____________ ❑ No test required; see form below ❑ Test required

Meningococcal (Meningitis) Vaccine *The risk of meningococcal disease may be increased in some subsets of college students. The American College Health Association (ACHA) 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.*
Dates received: 1st__________; 2nd__________; 3rd__________ **Not received:** ❑ Completed waiver enclosed

Recommended immunizations

Varicella (Chicken Pox) Vaccine *Based on guidelines from the American College Health Association (ACHA), this vaccination is recommended but not required. Consult your health care professional with questions.*
Varicella diagnosis date: ____________ **OR** **Vaccine:** ❑ Date received__________ ❑ Not taken

COVID-19 Vaccine: ❑ Date(s) received__________ / __________ ❑Not taken

COVID-19 Vaccine Type: ____

HEALTH CARE PROFESSIONAL INFORMATION & SIGNATURE:

Name ____ Telephone ______________________________

Address ____

Signature ____ Date ______________________________

Complete this *Tuberculosis Screening* section ONLY if TB test or screening listed was not completed within six months of enrollment.

Tuberculosis Screening

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, or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments.

1. 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.

2. Is the student a member of a high-risk group[1] (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).

3. Tuberculin Skin Test (must have been placed within six months prior to enrollment)
   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

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 within six months prior to enrollment)
   Date of x-ray: ________________ Result: ❑ normal ❑ abnormal

[1] Categories 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, Lusembourg, 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 one month) or other immunosuppressive disorders.

HEALTH CARE PROFESSIONAL INFORMATION & SIGNATURE:

Name ____ Telephone ____________________________

Address ____

Signature ____ Date ____________________________

****************END OF HEALTH CARE PROFESSIONAL SECTION****************

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.*
UVa-Wise does not offer coverage to students; it is the students' responsibility to obtain coverage. Please contact your local insurance agencies to see if they provide coverage, or visit websites such as www.heatlhcaremarketplace.com and www.healthcare.gov for additional information.

Insurance Company: Name________________________________ Policy Number________________________

Address________________________________ Group Number________________________

City/State/Zip____________________________ Telephone ________________________

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 Pre-Entrance Health 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** ______________

HEPATITIS B IMMUNIZATION WAIVERS FORM & MENINGOCOCCAL IMMUNIZATION WAIVER FORM

UVA Student & Employee Health Wise
The University of Virginia's College at Wise
1 College Avenue ◆ Wise, VA 24293-4412

PHONE 276-376-3475
FAX 276-328-3102

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 __________
Date of birth ______________________________ Social security number (last 4 digits only): *XXX - XX -* ___ ___ ___ ___

Parent/legal guardian of minor student:
Name ___________________________________ Signature _________________________________ 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 __________
Date of birth ______________________________ Social security number (last 4 digits only): *XXX - XX -* ___ ___ ___ ___

Parent/legal guardian of minor student:
Name ___________________________________ Signature _________________________________ Date __________

STUDENT ATHLETE MEDICAL HISTORY

Department of Athletics – Athletic Training
The University of Virginia's College at Wise
1 College Ave Wise, VA 24293

Phone: 276-376-4591
Fax: 276-376-1023
Web: www.uvawisecavs.com

Name: ____ Sex: F M Age: _____ Date of Birth: ____/____/_____

Home Address: ____

Year: FR SO JR SR Sport: _________________________ Cell Phone: ______________________

Family Physician: ____ Phone: ___________________________

Explain any YES answers below:

1. Have you had a medical illness or injury since your last check up or sports physical? Y N
2. Do you have an ongoing or chronic illness? Y N
3. Have you ever been hospitalized overnight? Y N
4. Have you ever had surgery? Y N
5. Are you currently taking any prescription, non-prescription medications, or using an inhaler? Y N
6. Have you ever taken any supplements or vitamins to help gain/lose weight or improve performance? Y N
7. Do you have any allergies (pollen, medicine, food, bees, etc.)? Y N
8. Have you ever had a rash or hives develop during or after exercise? Y N
9. Have you ever passed out during or after exercise? Y N
10. Have you ever been dizzy during or after exercise? Y N
11. Have you ever had chest pain during or after exercise? Y N
12. Have you ever had a racing of your heart or skipped heartbeats? Y N
13. Have you ever had high blood pressure or high cholesterol? Y N
14. Have you ever been told that you have a heart murmur? Y N
15. Has anyone in your family died of heart problems or a sudden death prior to age 50? Y N
16. Have you ever become ill from exercising in the heat? Y N
17. Have you ever been dizzy or passed out in the heat? Y N
18. Do you have any history of sickle cell anemia or sickle cell trait? Y N
19. Have you had a severe viral infection (i.e. mononucleosis) in the last month? Y N
20. Do you have any current skin problems (itching, rash, acne, etc.)? Y N
21. Have you ever had a head injury or concussion? Y N
22. Have you ever lost consciousness? Y N
23. Do you have frequent or severe headaches? Y N
24. Have you ever had a seizure? Y N
25. Have you ever had numbness, tingling in your arms, hands, legs, or feet? Y N
26. Have you ever had a stinger, burner or pinched nerve? Y N
27. Do you cough, wheeze, or have trouble breathing during/after activity? Y N
28. Do you have asthma? Y N
29. Do you have seasonal allergies requiring medical treatment? Y N
30. Do you use any protective or corrective devices (braces, orthotics, hearing aid, etc.)? Y N
31. Have you had any problems with your eyes/vision? Y N
32. Do you wear glasses, contacts, or protective eyewear? Y N
33. Have you ever had a sprain, strain, swelling after injury? Y N
34. Have you broken/fractured a bone or dislocated a joint? Y N
35. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? Y N

    If YES, circle and explain below:
    head neck back chest shoulder
    elbow forearm wrist hand finger
36. Do you want to weigh more than you do now? Y N
37. Do you lose weight regularly to meet requirements for your sport? Y N
38. Have you ever been diagnosed with COVID-19? Y N
39. Have you ever received a COVID-19 vaccine? Y N
40. Have your athletic activities ever been interrupted because of mental or emotional problems? Y N
41. Do you feel stressed out? Y N

FEMALES ONLY:

42. When was your first menstrual period? __________________
43. When was your most recent menstrual period? _____________
44. How much time from the start of one period to the start of another? ____
45. How many periods did you have in the past year? ___________
46. What was longest time between periods in last year?________

MALES ONLY:

47. History of testicular torsion or testicular cancer? Y N

PLEASE EXPLAIN "YES" ANSWERS (List by question #):

____
____
____
____

I hearby state that, to the best of my knowledge, my information and answers to the above questions are compete and correct. I understand that my records will be destroyed five (5) years after completion of athletic participation.

Signature: ______________________________ ***Date:***_____________

PRE-PARTICIPATION PHYSICAL EVALUATION for STUDENT ATHLETES

Department of Athletics – Athletic Training
The University of Virginia's College at Wise
1 College Ave Wise, VA 24293

Phone: 276-376-4591
Fax: 276-376-1023
Web: www.uvawisecavs.com

Name: ____ Date of Birth: ____/____/_____

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

Physical Evaluation:

Height:__________ Weight________ Pulse________ BP_____/______ Respiratory________

Vision R 20/_____; L 20/_____ Corrected: Y N Pupils: Equal Unequal

EXAM	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wristband		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

CLEARANCE

❑ Cleared

❑ Cleared after completing evaluation/rehabilitation: ____

____

❑ Not cleared for this reason: ____

____

PHYSICIAN

Print name:_______________________________ Phone: ___________________________

Address:____

Signature:____ MD DO Date:________________