Health and Immunization Record

COMMONWEALTH OF VIRGINIA LAW AND/OR HOLLINS UNIVERSITY **REQUIRES** THAT THE HEALTH RECORD FORM AND CERTIFICATE OF IMMUNIZATION BE COMPLETED AND SUBMITTED BY **ALL** RESIDENTIAL STUDENTS TO THE STUDENT HEALTH & COUNSELING SERVICES CENTER **PRIOR TO ENROLLMENT** AT HOLLINS UNIVERSITY

Send forms directly to: Hollins University Health and Counseling Services, 7916 Williamson Rd., Box 9644, Roanoke, VA 24020
Questions please call: (540) 362-6444 **Fax records to:** (540) 362-6273

Completed forms must be returned no later than July 1 for fall semester and December 1 for spring semester

Section I: Personal Information

Name _____ **Student ID#**_____
Last First Middle **(Student ID # is Required to Process this form.)**

Date of Birth _____/_____/_____ **Sex** _____ **Marital Status** _____**Race**_____
Mo Day Year

Local Address _____
(If living off campus) No. & Street City State Zip

Permanent Address _____
No. & Street City State Zip

Email Address_____ (_____)_____ (_____)_____
Home Phone Cell Phone

In Case of Emergency, Notify _____ (_____) _____ _____
Name Telephone Relationship

Family Physician_____ _____
Name Address

Medical Insurance Company_____ **Policy No.** _____
Name

Type of plan: ☐ **HMO** ☐ **PPO** ☐ **Indemnity** ☐ **Other** ☐ **Uninsured**

Please include a copy (front & back) of your insurance card and/or prescription card. We will need this information for prescriptions and any outside referrals.

Medical History (Confidential)

1. Name any chronic illness or medical conditions for which you are being treated. Please also list any hospitalizations/surgeries:

_____

_____

2. List any medications you are currently taking:_____

_____

3. List any medicine, food, or environmental substance to which you are ALLERGIC and describe allergic reaction.

_____

_____

Over 18: I, hereby, give Health & Counseling Services permission to treat me whenever I present myself to the Center.

_____ _____
Student's Signature Date

Under 18: Statement must be signed by parent of guardian if student is under 18 years of age.
I/we, the parents of _____ hereby authorize and give permission to the Health & Counseling Services to treat my/our child whenever my/our child presents to the Center.

_____ _____
Parent/Guardian Signature Date

Section II: Immunization Record IMPORTANT REQUIREMENT

Commonwealth of Virginia Law and Hollins University require all students to submit a health record with documented immunizations. This MUST be signed by a health care provider, and all immunizations must be current.†

NOTE: In case of an incomplete immunization record, preregistration for the following semester will be blocked.

REQUIRED IMMUNIZATIONS†	VACCINE DOSES ADMINISTERED			
HEPATITIS B (For *combined Hep. A + B*, do not use this line. Instead, check here:____ and complete the appropriate line in *"Recommended"*) Titer ☐ Pos ☐ Neg ____ / ____ / ____ Mo Day Yr	#1 ____ / ____ / ____ Mo Day Yr	#2 ____ / ____ / ____ Mo Day Yr	#3 ____ / ____ / ____ Mo Day Yr	Date series completed ____ / ____ / ____ Mo Day Yr
MENINGOCOCCAL VACCINE Must have at least one vaccine after the age of 16	#1 ____ / ____ / ____ Mo Day Yr	#2 ____ / ____ / ____ Mo Day Yr		
MEASLES, MUMPS, RUBELLA (MMR) Students born before 1957 are not required to have a second MMR vaccination.	#1 ____ / ____ / ____ Mo Day Yr	#2 ____ / ____ / ____ Mo Day Yr	Titers only needed if dates unavailable Measles Titer ☐ Pos ☐Neg ____ / ____ / ____ Mo Day Yr Mumps Titer ☐ Pos ☐ Neg ____ / ____ / ____ Mo Day Yr Rubella Titer ☐ Pos ☐ Neg ____ / ____ / ____ Mo Day Yr	
TETANUS DIPHTHERIA Adult pertussis **(TDAP)** On or after 2011	____ / ____ / ____ Mo Day Yr			
POLIOMYELITIS (OPV or IPV)	Have you completed the series? ☐ yes ☐ no		____ / ____ / ____ Mo Day Yr Date completed	
VARICELLA (two doses one month apart for adults with no history of disease)	#1 ____ / ____ / ____ Mo Day Yr	#2 ____ / ____ / ____ Mo Day Yr	☐ Had Disease Date : ___ / ___ / ___	Titer ☐ Pos ☐ Neg ____ / ____ / ____

RECOMMENDED - PLEASE INCLUDE VACCINATION DATES			
HPV, Quadrivalent or Bivalent (age 26 and under)	#1 ____ / ____ / ____	#2 ____ / ____ / ____	#3 ____ / ____ / ____
HEPATITIS A	#1 ____ / ____ / ____	#2 ____ / ____ / ____	
Combined Hepatitis A + B Vaccine **Hepatitis B** is required. See above.	#1 ____ / ____ / ____	#2 ____ / ____ / ____	#3 ____ / ____ / ____
PNEUMOCOCCAL VACCINE (high-risk persons)	#1 ____ / ____ / ____		

†MEDICAL EXEMPTION

☐ DTP ☐ Td ☐ Hepatitis B ☐ Measles ☐ Rubella ☐ Mumps ☐ Meningococcal Vaccine ☐ OPV

As specified in §23-7.5 of the Code of Virginia, I certify that administration of the vaccine(s) designated above would be detrimental to this student's health.

The vaccine(s) is (are) specifically contraindicated because _____

This contraindication is ☐ permanent (or) ☐ temporary and expected to preclude immunization until _____

_____ _____

Signature of Physician or Health Department Official Date

†Religious Exemption: Any student who objects on the grounds that administration of immunizing agents conflicts with religious beliefs or practices shall be exempt from the immunization requirements unless an emergency or epidemic disease has been declared by the Board of Health. An affidavit of religious exemption must be submitted on a Certificate of Religious Exemption (Form CRE-1) which may be obtained at any local health department, school division superintendent's office or local department of social services.

HEALTH CARE PROVIDER

***This form will not be accepted if not signed by a health care provider**

Printed Name_____ Phone _____

Address_____

Signature_____ Date_____

COVID-19 Vaccine: Hollins University **requires ALL students** to be fully vaccinated (including booster) for COVID-19 and you must **provide a copy of your vaccination record**. For questions regarding this requirement contact Hollins Health & Counseling Services.

Initial vaccine brand: _____ Date of #1: ___/___/___ Date of #2 (if applicable): ___/___/___ Booster brand: _____ Date: ___/___/___

Tuberculosis Screening: Required of All Students

Fill out the first section and take to your health care provider with your immunization record

_____ _____ _____

Name Date of birth Student ID Number

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER. TB screening must be completed within six months.
Please answer the following questions.

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 (TST), Quantiferon Gold TB test (QFT), chest x-ray (CXR) and sputum evaluation as indicated. Documentation required that all tests are negative or that treatment is effective and student free of communicable disease.

2. **Is the student a member of a high-risk group?** ☐ YES ☐ NO

   Categories of high-risk students include those: with HIV infection; who inject drugs; who have resided 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 > 15 mg/d for > 1 month) or other immunosuppressive disorders.

   If NO, continue to question 3.

   If YES, obtain QFT (preferred) or perform TST

   QFT-TB Date obtained: ____/____/_____ **Result:** ☐ Positive ☐ Negative

   OR TST: Date given: ____/____/_____ Date read: ____/____/_____ Result: _____mm (transverse induration)

   Interpretation (based on mm of induration as well as risk factors) ☐ Positive ☐ Negative

   If positive, please obtain QFT: Date obtained: ____/____/_____ **Result:** ☐ Positive ☐ Negative

   If positive QFT, obtain CXR (if symptoms):

   Date: ____/____/_____ **Result:** ☐ Normal If abnormal CXR, return to Question 1 - yes

   If normal CXR, INH initiated Date: ____/____/_____ Completed: ____/____/_____

3. **Was the student born in or has the student traveled to countries OTHER than those on the following list? ☐YES ☐NO**

   Albania, American Samoa, Andorra, Antigua and Barbuda, Aruba, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Curacao, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Monaco, Montenegro, Montserrat, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tokelau, Tonga, Trinidad & Tobago, United Arab Emirates, United Kingdom, United States Virgin Islands, West Bank and Gaza Strip, United States of America

IF NO, please sign below.*

If YES, obtain QFT: Date obtained: ____/____/_____ **Result:** ☐ Positive ☐ Negative (If negative, sign below)

If positive without symptoms, INH initiated Date: ____/____/_____ Completed: ____/____/_____

HEALTH CARE PROVIDER

***Signature required as validation of correct information for TB assessment**
***This form will not be accepted if not signed by a health care provider**

Printed Name_____ Phone _____

Address_____

Signature_____ Date_____

Student's Name: _____**Date of Birth**_____

Section III: Physician's Health Evaluation (exam within twelve months of entering Hollins University)

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all abnormal answers. The information supplied will be used only as a background for providing health and mental health care, if this is necessary. This information is strictly for the use of the Health and Counseling Services and will not be released without student consent.

Exams by parent or legal guardian not accepted

Height (inches)_____

Weight (lbs.)_____

Temperature_____

Blood Pressure_____

Pulse_____

Un-Corrected vision

Right 20/____

Left 20/_____

Corrected vision

Right 20/____

Left 20/_____

Hearing

Right_____

Left_____

Please complete the following lab work if indicated

Urinalysis: Neg_____ Pos_____

Hemoglobin/Hematocrit_____/_____

PLEASE INDICATE ANY ABNORMALITIES IN THE FOLLOWING:

	Normal	Abnormal		Normal	Abnormal
Skin			**Breasts**		
Lymph			**Lungs**		
Eyes			**Heart**		
Ears			**Abdomen**		
Nose			**Back/spine**		
Mouth/throat			**Genitalia**		
Neck/thyroid			**Extremities**		
			Neurological		

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: □ **Limited** □ **Unlimited**

How long have you known this student? _____

Is the patient now under treatment for any medical or emotional condition? □ Yes □ No

Does student take any medications regularly? □ Yes □ No

Do you have any recommendations regarding the care of this student? □ Yes □ No

Comments_____

If patient is prescribed medication for ADD/ADHD, a letter from the physician with documentation is **required**.

HEALTH CARE PROVIDER

***Signature required as validation of physical exam**

***This form will not be accepted if not signed by a health care provider**

Printed Name_____ Phone _____

Address_____

Signature_____ Date_____

To Be Completed By

New Student Prospective Athlete

As a prospective student-athlete for Hollins University, you are **required** to have a **complete physical exam** before you can participate in any athletic program activities at Hollins University.

The staff of the Health & Counseling Services Center is committed to maintaining strict confidentiality. However, in order for you to perform safely as a student-athlete, the athletic department may request knowledge of certain confidential health information and/or conditions. This may include information such drug and alcohol use, current medications, allergies (e.g., bee stings, drug allergies), need for corrective lenses, and/or history of any medical condition or injury that may need to be monitored during your participation in collegiate sports.

We believe firmly in the benefits of physical fitness for all and will support you to help you reach your goals as a student-athlete. Our goal is to help you to safely participate in athletic programs and activities, which may require confidentially providing information to the athletic department as needed in order to support that goal.

Your first-year or transfer **Health and Immunization Record** form contains information that may be confidentially released to the athletic department in order for you to safely participate in athletic programs. It will be your responsibility to inform the Health & Counseling Services Center if you do not wish to release specific information to the athletic department.

I HAVE FULLY READ, UNDERSTAND AND AGREE TO THE ABOVE:

_____ _____

Student Signature **Date**

_____ _____

Parent/Guardian Signature if student under 18 **Date**

_____

Print Full Name

Please return this document along with your Health and Immunization Record to Health and Counseling Services