



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 CENTER PRIOR TO ENROLLMENT AT HOLLINS UNIVERSITY.

Send directly to: Hollins University, Health and Counseling Services, P. O. Box 9644, Roanoke, VA 24020-1644. Questions: call (540) 362-6444, fax (540) 362-6273.

This completed form must be returned by August 10 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 the Student Health Center permission to treat me whenever I present myself to the Center.

Student's Signature _____ Date _____

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

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.

All immunizations must be current.

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 but Not Required") Titer <input type="checkbox"/> Pos <input type="checkbox"/> 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	Titrers only needed if dates unavailable Measles Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg _____ / _____ / _____ Mo Day Yr Mumps Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg _____ / _____ / _____ Mo Day Yr Rubella Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg _____ / _____ / _____ Mo Day Yr	
TETANUS DIPHTHERIA Adult pertussis (TDAP) On or after 2006	____ / ____ / ____ Mo Day Yr			
POLIOMYELITIS (OPV or IPV)	Have you completed the series? <input type="checkbox"/> yes <input type="checkbox"/> 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	<input type="checkbox"/> Had Disease Date : _____ / _____ / _____	Titer <input type="checkbox"/> Pos <input type="checkbox"/> 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 ____ / ____ / ____		

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

Printed Name _____ Phone _____
 Address _____
 Signature _____ Date _____

†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.

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, QFT-TB test, chest x-ray 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) _____	<u>Un-Corrected vision</u>	<u>Hearing</u>	
Weight (lbs.) _____	Right 20/ _____	Right _____	*Please complete the following lab work if indicated*
Temperature _____	Left 20/ _____	Left _____	
Blood Pressure _____	<u>Corrected vision</u>		Urinalysis: Neg _____ Pos _____
Pulse _____	Right 20/ _____		Hemoglobin/Hematocrit _____
	Left 20/ _____		

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	*This form will not be accepted if not signed by a health care provider
Printed Name _____	Phone _____
Address _____	
Signature _____	Date _____

Prospective Athlete

New Students (First Year/Transfer)

As a prospective athlete for Hollins University, you will be **required** to have a **complete physical exam** before you participate in any athletic activities at Hollins University.

The staff of Health and Counseling Services works hard to maintain strict confidentiality. However, in order for you to perform safely as an athlete, the athletic department requests knowledge of certain information. This includes information concerning drug and alcohol use, current medications, allergies (e.g., bee stings, drug allergies), need for corrective lenses, and history of any medical condition or injury that may need to be monitored during your participation in sports.

Your freshman or transfer **Health and Immunization Record** form will contain information to be released to the athletic department. It will be your responsibility to inform us if you do not wish to release any specific information.

It is because of our strong concern for confidentiality that we want you to be aware of this procedure. Our aim is to help you to safely participate in the Hollins University athletic program. We believe firmly in physical fitness for all and will work with you to reach that goal.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT. (Please return this statement and your Health and Immunization Record to Health and Counseling Services.)

Signature

Date

Name: _____

Please Print