

**Student Health Form**

**(\*\* Please note this form is different from the Athlete Physical form\*\*)**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_

College Entrance Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Freshmen\_\_\_\_\_\_\_\_\_\_\_ Transfer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip Code)

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Insurance**

Health insurance is **required** for all full-time students while attending Averett University. Students must complete the online waiver providing proof of health insurance or enroll in the University Plan and will be billed accordingly.

**Please complete the information below and attach a copy of your health insurance card (front and back)**

**Insurance Company:** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_\_

Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder:** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last four digits of SSN \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* Please attach a copy of the front and back of your insurance card \*\***

**\*\*Students Must Answer All Questions \*\***

**Personal Medical History**

|  |  |  |
| --- | --- | --- |
| Abnormal Bruising No\_\_\_ Yes\_\_\_ | ADD/ADHD No\_\_\_ Yes\_\_\_ | Anemia No\_\_\_ Yes\_\_\_ |
| Asthma/Bronchitis No\_\_\_ Yes\_\_\_ | Cancer No\_\_\_ Yes\_\_\_ | Chickenpox No\_\_\_ Yes\_\_\_ |
| Depression/ No\_\_\_ Yes\_\_\_  Anxiety | Diabetes No\_\_\_ Yes\_\_\_ | Eating Disorder No\_\_\_ Yes\_\_\_ |
| Epilepsy/Seizures No\_\_\_ Yes\_\_\_ | Fainting No\_\_\_ Yes\_\_\_  Spells/Dizzy | Fatigue No\_\_\_ Yes\_\_\_ |
| Frequent Cold/ No\_\_\_ Yes\_\_\_  Sinus Infections | Hay Fever/ No\_\_\_ Yes\_\_\_  Seasonal Allergies | Head Injury/ No\_\_\_ Yes\_\_\_  Concussion |
| Hearing No\_\_\_ Yes\_\_\_  Problems | Heart Disease/ No\_\_\_ Yes\_\_\_  Heart Murmur | Hepatitis No\_\_\_ Yes\_\_\_ |
| Hypertension No\_\_\_ Yes\_\_\_ | Irritable Bowel/ No\_\_\_ Yes\_\_\_  Spastic Colon | Menstrual No\_\_\_ Yes\_\_\_  Problems |
| Obesity No\_\_\_ Yes\_\_\_ | Migraines/ No\_\_\_ Yes\_\_\_  Chronic Headaches | Mono No\_\_\_ Yes\_\_\_ |
| Recurrent No\_\_\_ Yes\_\_\_  Bladder/Kidney  Problems | Pelvic Infections/ No\_\_\_ Yes\_\_\_  STD’s | Pneumonia No\_\_\_ Yes\_\_\_ |
| Thyroid No\_\_\_ Yes\_\_\_  Disease | Scoliosis No\_\_\_ Yes\_\_\_ | Sickle-Cell No\_\_\_ Yes\_\_\_  Disease/Trait |
| Tuberculosis/ No\_\_\_ Yes\_\_\_  Lung Disease | Mental Health Issues No\_\_\_ Yes \_\_ | Suicidal No\_\_\_ Yes\_\_\_  Thoughts |
| Do you smoker/Vape No\_\_\_\_ Yes\_\_\_ |  |

**Have you ever had any of the following?**

Details of above, if necessary:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any illness/condition, not listed above, for which you are being treated:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete the following:**

List dates of any serious injuries, hospitalizations, illnesses or operations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any emotional disturbances or adjustment problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any medications you are currently taking, including dosage and scheduled administration, including over-the-counter.**

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | When Taken (daily, weekly, monthly) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Are you allergic to any medications? Yes\_\_\_ No\_\_\_ Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies other than Medications? Yes\_\_\_ No\_\_\_

Please specify your allergies below ( food, other):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Emergency Contact Information***

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permission for Treatment**

Averett University has my permission to perform or authorize routine medical care by a licensed health care professional, including check-ups, immunizations, and/or treatment for minor injuries and illness by the Director of Health Services RN, and to make referrals to area specialists and medical services. Under certain circumstances, the student may be transported to an area hospital for diagnosis and treatment.

This form must be signed by the student. If the student is a minor (under 18 years of age), this form must also be signed by the parent or legal guardian so that appropriate diagnosis and treatment may be promptly carried out. No major health services will be performed, except in an emergency, without a parent or legal guardian being contacted and fully informed if the student is a minor.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian (if student is a minor) Relationship Date

**Mental Health**

|  |
| --- |
| **If you require Mental Health Interventions/Assistance, Please contact our counseling services at:**  [**Counseling@averett.edu**](mailto:Counseling@averett.edu) |

**Special Needs**

|  |
| --- |
| **If you have a disability, you can request academic ADA accommodations for the classroom; to begin this process, please connect with Holly Kilby:**  **(**[**hkilby@averett.edu**](mailto:hkilby@averett.edu)**; 434.791.5788).** |

**Terms**

I certify that the information I have provided on this form is truthful, accurate, and complete to the best of my knowledge. I understand it will be used only by Averett University and will be maintained as confidential information in my student health record. This information will not be released without my written consent, except in cases of life threatening emergencies**. I also understand that information on this form is intended for medical services only. I also understand that my signature signifies permission for the release of medical information to appropriate college personnel.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian (if student is a minor) Relationship Date

***Return Forms to:***

**Averett University Office of Health Services**

**Student Success Building**

**420 W Main St**

**Danville, Virginia 24541**

***Or***

**Via email**

**Health@averett.edu**

**Required Immunizations**

**\*\* Please attach an official copy (high school transcript, health department, medical provider) of the following immunizations to this health form. If an official copy is not provided then the Physician MUST sign to certify immunization dates\*\***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Measles, Mumps, Rubella**  **MMR** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #2: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **OR Titer (Attach Copy)** |  |
| **Poliomyelitis**  **(OPV) or (IPV)** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #2: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #3: Date**  **\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #4: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_**  **MM DD YY** |
| **Hepatitis B** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #2: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #3: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **OR Titer:**  **(Attach Copy)** |
| **Diphtheria/Pertussis/Tetanus (Tdap) MUST be within 10 years** | **Date:**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** |  |  |  |
| **Covid -19 Vaccine**  **Moderna \_\_\_\_\_**  **Pfizer \_\_\_\_\_\_\_**  **J&J \_\_\_\_\_\_\_\_** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #2: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Booster If applicable**  **Date:**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** |  |

**Strongly Recommended Immunizations but not required**

|  |  |  |  |
| --- | --- | --- | --- |
| **Meningococcal Vaccine** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** |
| **HPV** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** |
| **Varicella Vaccine** | **Dose #1: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Dose #2: Date**  **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **MM DD YY** | **Or documented date of Chicken Pox disease**  **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**  **\*\*Or attach titer if one was done** |

**Meningitis Vaccine Waiver (Student must sign if vaccine was not received)**

The Code of Virginia (Chapter 340 23-7.5) requires that “each full-time student shall be vaccinated against Meningococcal (Meningitis) unless the student or, if the student is a minor, the student’s parent or legal guardian signs a written waiver stating that he or she has received and reviewed detailed information on the risks associated with Meningococcal (Meningitis) and the availability and effectiveness of any vaccine and has chosen not to be or not to have the student vaccinated.”

I have read the Frequently Asked Questions at *https://www.cdc.gov/meningococcal/about/index.html*, and reviewed the Averett University Statement on Recommended Immunizations available at [*www.averett.edu*](http://www.averett.edu)*.* I understand therisks associated with the disease, including the effectiveness and availability of any vaccine against Meningococcal, and decline to receive the immunization.

**Student’s signature for waiver** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician verification of vaccine records if official copy is not attached:**

**Healthcare Provider’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD/NP Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider’s Name Printed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tuberculosis Screening**

**SECTION A: PAST DIAGNOSIS OF TUBERCULOSIS (TB)**

1. Have you ever been sick with tuberculosis? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_

2. Have you ever had a positive PPD or Mantoux test? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_

**SECTION B: TUBERCULOSIS (TB) EXPOSURE RISK QUESTIONNAIRE**

1. Have you previously been in a health-related academic program/major? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

2. Were you born in, or ever lived, worked or traveled for more than one month in any of the following: Africa, Asia, South America, Central America or Eastern Europe? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

3. Are you HIV positive or chronically immunocompromised? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

4. Do any of the following conditions or situations apply to the patient?

a) Do you have a persistent cough, fever, night sweats, fatigue, loss of appetite, or weight loss? Yes \_\_\_ No \_\_\_

b) Have you ever lived with or been in close contact to a person known/suspected of having TB? Yes \_\_\_ No \_\_\_

If you answered YES to any of the above, a PPD IS REQUIRED. PPD test (skin test within the past 3 months):

Placement Date\_\_\_/\_\_\_/\_\_\_ Date Read \_\_\_/\_\_\_/\_\_\_ (Circle one) Negative Positive If positive, \_\_\_\_\_\_\_mm

**\*\* If PPD is POSITIVE, a Chest X-Ray and Copy of the Report is required. \*\***