# Averett University
# Health Form

**To All Students:**

Based on a recommendation from the Virginia Department of Health and the American College Health Association, **Averett University requires that current health and immunization records be on file for all students.** Information contained herein is confidential as a part of your records and will not be disclosed without your written permission, except in the event of an emergency.

## To Be Completed By Student *(please print)*

Name________________________________________________ ______________
(Last) (First) (Middle) Student ID#

Sex ____ Marital Status ____ Date of Birth ________________ College Entrance Date ________________ Freshman ____ Transfer ____

Home Address ____________________________________________________________
(Street)

____________________________________________________________
(City) (State) (Zip Code)

Home Phone ______________________________ Cell Phone ______________________________

## Students Must Answer All Questions
## Personal Medical History

Have you ever had the following?

| | | | | | |
|---|---|---|---|---|---|
| Asthma/Bronchitis | No___ Yes___ | Diabetes | No___ Yes___ | Thyroid Disease | No___ Yes___ |
| Chickenpox | No___ Yes___ | Mental Health Issues | No___ Yes___ | Pneumonia | No___ Yes___ |
| Frequent Cold/Sinus Infection | No___ Yes___ | ADD/ADHD | No___ Yes___ | Pelvic Infections/ STD's | No___ Yes___ |
| Hypertension | No___ Yes___ | Depression/ Anxiety | No___ Yes___ | Menstrual Problems | No___ Yes___ |
| Heart Disease/Heart Murmur | No ___Yes ___ | Suicidal Thoughts | No___ Yes___ | Recurrent Bladder/ Kidney Problems | No___ Yes___ |
| Fainting Spells/ Dizzy | No___ Yes___ | Eating Disorder | No___ Yes___ | Sickle-Cell Disease | No___ Yes___ |
| Epilepsy/Seizures | No___ Yes___ | Fatigue | No___ Yes___ | Migraines/Chronic Headaches | No___ Yes___ |
| Head Injury/Concussion | No___ Yes___ | Mono | No___ Yes___ | Scoliosis | No___ Yes___ |
| Irritable Bowel/ Spastic Colon | No___ Yes___ | Hepatitis | No___ Yes___ | Hearing Problems | No___ Yes___ |
| | | Obesity | No___ Yes___ | | |
| | | Abnormal Bruising | No___ Yes___ | | |
| | | Anemia | No___ Yes___ | | |

Details of above, if necessary:

____________________________________________________________

____________________________________________________________

**Please complete the following:**

List dates of any serious injuries, hospitalizations, illnesses or operations.
❒ None or, if applicable, please list________________________________________

Describe any emotional disturbances or adjustment problems.
❒ None or, if applicable, please describe________________________________________

List any medications you are currently taking, including dosage and scheduled administration.
❒ None or, if applicable, please list________________________________________

Are you allergic to any medications? Yes____ No____ Specify ______________________________

Other allergies: ______________________________________________

## Terms

Information on this form may be necessary in the event of an emergency. All omissions or incomplete information on this form are the responsibility of the student and his/her healthcare provider. **This completed form must be filed at Averett University at the beginning of the school year.**

**Student's Signature** ______________________________ **Date** ______________________

***Emergency Contact Information:***

| | |
|---|---|
| **Name:** ______________________ | **Name:** ______________________ |
| **Address:** ______________________ | **Address:** ______________________ |
| **City/State:** ______________________ | **City/State:** ______________________ |
| **Phone #:** ______________________ | **Phone #:** ______________________ |
| **Relationship:** ______________________ | **Relationship:** ______________________ |

## Required Immunizations

## MUST BECOMPLETED BY A PHYSICAN

An official copy (high school transcript, health department, medical provider) of the following immunizations **must** be attached to this health form.

**MMR # 1** ____________
**MMR # 2** ____________
**Tetanus** *(T.D., tdap - must be within last 10 years)* __________
**Polio** ____________
**Hepatitis B Series** ____________, ____________, ____________

***Recommended*** *(but not required)* ***Immunization -- Meningococcal Vaccine*** *Date of shot* ____________________
*I have reviewed the Averett University Statement on Recommended Immunizations available at www.averett.edu. I have been informed and understand the benefits of the meningococcal vaccine and decline to receive the immunization.*

*Student's signature for waiver* ______________________________ *Date* ____________________

**Tuberculosis Screening** (complete both questions 1 and 2)

1. Does the student have signs or symptoms of active TB disease? No____Yes ____
   If No, proceed to question 2.

2. Is the student a member of a high-risk group or is the student entering the health profession? No____Yes ____
   If YES, perform TB skin test (Mantoux only).

**Tuberculin Skin Test** (within one year) Date given ___________ Date read _________ Induration ________________mm
Positive ___ Negative ___ **Chest X-ray** (required if skin test is positive) Date ______________ Report Results _______________

**Physician/PA/NP Signature** ______________________________ **Date** ____________________

**Physician/PA/LP Last Name** (Print) ______________________________

**Address** ______________________________

**Telephone Number** ______________________________

**Return to: Jill Adams, Director of Health & Wellness/Title IX Coordinator**
**Averett University**
**420 West Main Street**
**Danville, VA 24541**
**FAX (434) 791-5831**
**Phone (434) 791-5628**