Averett University

Health and Immunization Record

Name _____ Student ID _____

(Last) (First) (Middle)

Sex ___ Marital Status ___ Date of Birth _____ 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 ____/_____/_____

Students Must Answer All Questions

Personal Medical History

Have you ever had the following?

Abnormal Bruising No___ Yes___	ADD/ADHD No___ Yes___	Anemia No___ Yes___
Asthma/Bronchitis No___ Yes___	Cancer No___ Yes___	Chickenpox No___ Yes___
Depression/ Anxiety No___ Yes___	Diabetes No___ Yes___	Eating Disorder No___ Yes___
Epilepsy/Seizures No___ Yes___	Fainting Spells/Dizzy No___ Yes___	Fatigue No___ Yes___
Frequent Cold/ Sinus Infections No___ Yes___	Hay Fever/ Seasonal Allergies No___ Yes___	Head Injury/ Concussion No___ Yes___
Hearing Problems No___ Yes___	Heart Disease/ Heart Murmur No___ Yes___	Hepatitis No___ Yes___
Hypertension No___ Yes___	Irritable Bowel/ Spastic Colon No___ Yes___	Menstrual Problems No___ Yes___
Mental Health Issues No___ Yes___	Migraines/ Chronic Headaches No___ Yes___	Mono No___ Yes___
Obesity No___ Yes___	Pelvic Infections/ STD's No___ Yes___	Pneumonia No___ Yes___
Recurrent Bladder/Kidney Problems No___ Yes___	Scoliosis No___ Yes___	Sickle-Cell Disease No___ Yes___
Smoker No___ Yes___	Substance Abuse/ Alcohol Abuse No___ Yes___	Suicidal Thoughts No___ Yes___
Thyroid Disease No___ Yes___	Tuberculosis/ Lung Disease No___ Yes___	

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.

Circle **none** or, if applicable, please list _____

Describe any emotional disturbances or adjustment problems.

Circle **none** or, if applicable, please describe _____

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

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

Do you want/need a lockbox for your medication? Yes___ No___

Are you allergic to any medications? Yes___ No___ Specify _____

Do you have any allergies? Yes___ No___

Please specify your allergies below (medications, 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, 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.

In the event of an emergency medical care, every effort will be made to contact a parent or legal guardian.

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 Interventions

Have you ever had any treatment or counseling for any emotional, behavioral, or psychological condition?

Yes___ No___

Have you ever been treated with any medication for psychiatric reasons?

Yes___ No___

If the answer to any of the above questions is YES:

- A full report from your physician, psychiatrist, certified therapist, or counselor is required.
- The full report will include a statement of the diagnosis, treatment, response to treatment and need for follow up.
- This report should be directed to the Averett University's Health and Wellness Center, Head Athletic Trainer (if applicable), Residence Life (if applicable), and Counseling and Psychological Services.
- This report will not be released without the written consent of the student.

Special Needs

Do you consider yourself handicapped or disabled in any way that requires you to receive special consideration from the University?

Yes___ No___ I Choose to Not Identify ___

If yes, you may e-mail Erin Schlauch, eschlauch@averett.edu, to request accommodations.

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

Averett University – Immunization Record

(Must be completed, signed, and dated by a licensed healthcare professional)

Required Immunizations/Titers

1. MMR (Measles, Mumps, Rubella) **OR** Titer (Two doses live vaccine at or after 12 months of age, at least 1 month apart)

   Dose #1 __/__/____

   Dose #2 __/__/____

Titer results	Measles	Negative	Positive	
	Mumps	Negative	Positive	
	Rubella	Negative	Positive	Titer Date __/__/____

2. Diphtheria/Pertussis/Tetanus (TDap) (Booster within last 10 years) Date __/__/____

3. Hepatitis B Vaccine **OR** Titer (Series of 3 vaccines)

   Dose #1 __/__/____
   Dose #2 __/__/____
   Dose #3 __/__/____

   Titer results Negative Positive Titer Date __/__/____

4. Varicella Vaccine OR Titer (Two doses of vaccine one month apart)

   Dose #1 __/__/____
   Dose #2 __/__/____

   Titer results Negative Positive Equivocal Titer Date __/__/____

5. Polio Last Dose __/__/____

6. Tuberculosis Screening (please see page 7 for Tuberculosis Risk Assessment)

7. ***Recommended Immunization*** *(but not required)* – ***Meningococcal*** **Vaccine** (please see page 6)

Averett University – Immunization Record, cont.

(Must be completed, signed, and dated by a licensed healthcare professional)

Recommended Immunization *(but not required) –* ***Meningococcal Vaccine*** Date 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 risks associated with the disease, including the effectiveness and availability of any vaccine against Meningococcal.

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* _____

Verified by:

Healthcare Provider's Signature _____ RN/LPN/NP/MD Date _____

Provider's Name Printed _____

Address _____

Phone _____

Please return forms directly to Student Engagement at:	**Student Engagement Contact Info:**
Averett University Student Engagement	Jessica McConnell
420 West Main Street	434-791-5718
Danville, VA 24541	jmcconnell@averett.edu

Tuberculosis Risk Assessment

(Must be completed, signed, and dated by a licensed healthcare professional)

Yes	No	
		1. Have you ever been sick with TB?
		2. Do you have ANY of the following symptoms? Circle if applicable. Persistent cough Unexplained fever for more than one week Coughing up blood Loss of appetite Night sweats Unexplained weight loss Chest pain
		3. Do ANY of these situations apply to you? • Previously been in a health-related academic program/major? • History of positive PPD testing** • Close contact with someone diagnosed with or suspected of having tuberculosis • Use of injected drugs • Identified as medically underserved or low income • At risk of being infected with HIV (Human Immunodeficiency Virus) • Volunteer, reside, or an employee in a health care facility or congregate living setting (homeless shelter, nursing home, correctional facility)
		4. Do you have ANY of the following conditions that place you at increased risk for disease if infection occurs? Silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemia, lymphoma, or cancer of the head, neck, or lungs), gastrectomy or jejunoileal bypass, weight loss of at least 10% below ideal body weight, or prolonged corticosteroid or other immunosuppressive therapy
		5. Were you born in any of the following regions AND did you (or will you) arrive in the U.S. within the past 5 years? If so, circle region. Africa, Asia, South America, Central America, or Eastern Europe
		6. Have you ever traveled, lived, or worked within the last 5 years to one or more of the regions listed below with a stay exceeding 4 weeks? If so, circle region and indicate date of return. Africa, Asia, South America, Central America, or Eastern Europe

- **If you answered "No" to questions 1 – 6, TB testing is NOT required and you may ignore page 8 (in this case, a physician's signature is not needed).**
- **If you answered "Yes" to ANY question above, TB testing IS required. Please proceed to page 8.**
- **Note: Prior BCG Vaccine does NOT exempt one from this requirement (in this case, we recommend having IGRA Testing).**

TB (PPD) Skin Test**	**Chest X-Ray**	**Preventative Treatment**
Lot # _____ Expiration Date ___/___/____ Date Administered: ___/___/____ Time Placed: _____ Placed By: _____RN/NP/PA/MD Date Test Read: ___/___/____ Time Read: _____ Read By: _____RN/NP/PA/MD Induration : _____ mm Left or Right Forearm (Circle One) Result: Positive Negative **OR** – IGRA (i.e.: QFT-G or T Spot) – **Recommended if prior BCG Vaccine given.** (Attach copy of written report) Date Blood Drawn: ___/___/____ Method: QFT-G ___ T Spot ___ Other ___ Indeterminate: _____ Borderline (T Spot Only) (Not acceptable. Repeat test.) Result: Positive Negative	Required if skin test or IGRA is positive Date of X-Ray: ___/___/____ Result: Normal Abnormal (Attach a copy of written report)	All students with a positive skin test or IGRA, with no signs of active disease on chest X-Ray, should receive a recommendation to be treated for latent TB with appropriate medication. Drug Prescribed: _____ Duration of treatment regimen: _____ Patient Declined: _____ Completed: _____ Ongoing: _____

****If history of positive PPD, a Chest X-Ray and an attached copy of the written report is required.**

Verified by:

Healthcare Provider's Signature _____ RN/LPN/NP/MD Date _____

Provider's Name Printed _____

Address _____

Phone _____