SHENANDOAH UNIVERSITY

Exam Date_____
Resident or Commuter
Year_____
Major_____
SU ID# _____
Rev. 2013 – office use

Health and Insurance Requirements For General Admissions Students

(College of Arts and Science, School of Business, Conservatory)

Mary B. Wilkins Wellness Center, 1460 University Drive, Winchester, Virginia 22601
Toll Free: 1-800-432-2266 Phone: (540) 665-4530
wwcenter@su.edu

Faxed copies will not be accepted

All students must have a completed health form on file. All immunizations must be completed. A *photocopy* of your insurance card (front and back) must be attached. This form must be completed and returned by December 15th for the spring semester, May 10th for the summer semester and August 1st for the fall semester registrants. The original health form and insurance information should be mailed to the Wilkins Wellness Center prior to the due date. Faxes are not accepted.

It is your responsibility to meet any additional requirements mandated by your program major.

Student athletes: Additional questionnaire and health insurance information is required by the Athletic Department in addition to Shenandoah University's Health Form below.

Medical Consent Form/Emergency Contact Information

I hereby give permission to the Wilkins Wellness Center at Shenandoah University to administer medical treatment to me or my minor child, including treatment of minor illness, injuries, medical emergencies, and required or recommended immunizations. I give my consent to share medical information with any hospital or emergency medical personnel in the case of an emergency. I understand that the Wilkins Wellness Center staff will discuss with the Athletics Department information about my health which might affect my participation in team sports.

Student Name (Print):_____ Signature _____

Student's Home Address: _____ Student's (cell) number: _____

Field of Study/Major: _____ Academic Year: _____

Graduate or Undergraduate: _____ Resident or Commuter: _____

Email address: _____

SS# _____ Date of Birth _____

Emergency Contact Person: _____

Address: _____City:_____ State: _____Zip:_____

Home Phone: _____ Work Phone: _____ Cell: _____

Name: _____ ID#: _____ Date of Birth: _____

Immunization History:

(*To be completed by Health Care Professional*)

Record complete dates in chart below

IMMUNIZATIONS	Date of Immunization	Date of titer and results if no recorded date of immunizations	
Measles, Mumps Rubella vaccine #1 or titer			N/A
Measles, Mumps Rubella vaccine #2 or titer			N/A
Polio (last date in series only) or titer			N/A
Tetanus, Diphtheria, Pertussis (Adult)		N/A	N/A
Meningitis (recommendation) or waiver		N/A	N/A
Hepatitis B Series (3 dates), waiver, or titer	1)	2)	3)

TB assessment (included on page 5) **Date: _____ Neg: _____ Pos: _____ (TST required for positive)**

Chest X-Ray Results *(if a previous positive PPD)*: **Date: _____ Neg: _____ Pos: _____**

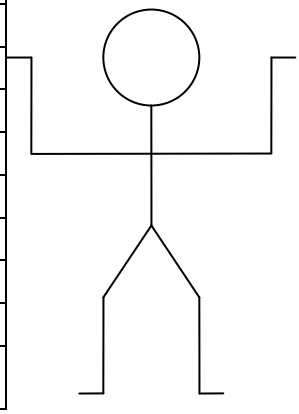
(A copy of the radiology report is required)

PHYSICAL EXAMINATION

Vital Signs: Ht: _____ Wt:_____ BP:_____ Pulse:_____ Temp:_____ LMP:_____ BMI: _____

Vision: OD: _____ OS:_____ OU:_____ Rx Lenses? Y N Contact Lenses? Y N

Physical Examination	Normal	Abnormal	NOTES	DTR's
HEENT				
Respiratory				
Cardiovascular				
Gastrointestinal				
Genitourinary (testicles) *			Glucose _____Protein _____Blood _____Leuk _____	
Musculoskeletal				
Metabolic/Endocrine				
Derm				
Lymph				
Neuro / Psychiatric				



*** Testicle exam required for men participating in sports.**

Additional Comments: _____

Health Care Provider: (Print name) _____Signature: _____

Phone#:_____ Date: _____

Name: _____ ID#: _____ Date of Birth: _____

PERSONAL HEALTH HISTORY

(*To be completed by the student*)

Allergies (Medication/Food / Environmental/Latex):_____

Medications taken daily or as needed: _____

Surgeries: _____

Check any of the following that apply to your personal health history and explain below:

_____	**Psychiatric Disorder (including anxiety / depression)**	_____	**Liver Disease (i.e., Hepatitis)**
_____	**Headaches/Migraines**	_____	**Diabetes**
_____	**Neurological Disorder (seizures, migraines)**	_____	**Renal Disease (Kidney)**
_____	**Visual Difficulties**	_____	**Cancer**
_____	**Respiratory Disease (including asthma / Reactive Airway Disease)**	_____	**Skin / Dermatological Disorder**
_____	**Cardiac Disorder / Hypertension / Cholesterol**	_____	**Immune suppressed**
_____	**Gastrointestinal Disorder**	_____	**Other**
_____	**Male/Female issues**		

Explain any check marks above: _____

Significant Family Health History: _____

Health Insurance Information

Students are <u>required</u> to provide proof of health insurance coverage and must maintain healthcare insurance throughout all academic and clinical years. A <u>copy</u> of the insurance card (front and back) must accompany this form. <u>Students who do not provide proof of insurance will be billed for the university policy</u>.

If you do not have insurance and you are interested in the University sponsored plan, visit our website at* http://www.su.edu/student_life/9687729F48D143B9B5E67FAECA342789.asp *for more information.

Health Insurance Provider: _____

PCP Contact Information: _____

<u>Acknowledgement Statement</u>

I, _____, agree that I have received and understand Shenandoah University's requirements regarding the need for health history and insurance information. These requirements and necessary forms have been made available to me. I agree that I am responsible for providing the above information within the required time-frame.

<u>I understand that I must provide proof of current health insurance coverage (photocopy of insurance card or military identification).</u> I also acknowledge that all health and insurance information provided on the health form is true and accurate. I will provide the Wilkins Wellness Center with any additional information that may be requested to verify accuracy of the information provided on the Shenandoah University Health form.

Name: _____ ID#: _____ Date of Birth: _____

Shenandoah University Immunization Waiver Form

Meningococcal Vaccine Waiver

Virginia Law 23-7.5 requires that all students be vaccinated with the meningococcal vaccine or sign a waiver declining the vaccination. In order to make an informed decision regarding immunization against meningococcal disease, please read the attached information from The CDC at http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf and American College Health Association at http://www.acha.org/projects_programs/meningitis/index.cfm.

To be completed by students 18 years of age or older if you decide not to have the vaccination:

By my signature below, I certify that, I choose not to be vaccinated against meningococcal disease.

Signature of Student: _____ Date: _____

To be completed by parent or guardian of students under the age of 18 that you do not want your child to be vaccinated:

I, _____, the parent or legal guardian of _____ certifies I choose not to have my child, _____, vaccinated against meningococcal disease.

Printed name of parent/guardian: _____ Date: _____

Signature of parent/guardian: _____

Hepatitis Vaccination Waiver

Virginia Law 23-7.5 requires that all students be vaccinated with the hepatitis vaccine or sign a waiver declining the vaccination series. In order to make an informed decision regarding immunization against hepatitis disease, please read the attached information from The CDC at http://www.cdc.gov/hepatitis/index.htm.

To be completed by *students 18 years of age or older* if you decide not to have the vaccination:

By my signature below, I certify that, I choose not to be vaccinated against hepatitis disease.

Signature of Student: _____ Date: _____

To be completed by *parent or guardian* of students under the age of 18 that you do not want your child to be vaccinated:

I, _____, the parent or legal guardian of _____ certifies I choose not to have my child, _____, vaccinated against hepatitis disease.

Printed name of parent/guardian: _____ Date: _____

Signature of parent/guardian: _____

Wilkins Wellness Center
Tuberculosis Risk Assessment Form

Student _____ ID # _____
Major: _____

The Centers for Disease Control and Prevention and the United State Public Health Service recommend that tuberculosis skin testing be performed on all individuals who may be at increased risk of tuberculosis as a result of a medical condition or previous residence in a country with an increased prevalence of tuberculosis.

Please complete the following form completely. Place a checkmark in the box in front of the section if any item in the section is true for you. **IF YOU CHECK ONE OF THE BOXES IN SECTIONS 1 – 4 YOU ARE REQUIRED TO HAVE A TUBERCULOSIS (PPD) SKIN TEST.** Check the box at the bottom of the page if sections 1-4 do not apply to you. Sign and date the form at the bottom. If you are under eighteen years of age, your parent or guardian will need to sign the form.

⬭ **Section 1:** Check this box if you have any of the following **Possible Symptoms of Tuberculosis:**
- Unexplained weight loss
- Unexplained elevation of temperature for more than one week
- Unexplained night sweats
- Unexplained persistent cough for more than 3 weeks
- Unexplained cough productive of bloody sputum

⬭ **Section 2:** Check this box if you have any of the following **Risk Factors for Tuberculosis Infection:**
- Close contact with a known case of active tuberculosis
- Use of illegal injected drugs
- HIV (Human Immunodeficiency Virus) Infection
- Health Care Worker
- Resident or employee in a congregate living setting (nursing home, homeless shelter, correctional facility)

⬭ **Section 3**: Check this box if you have any of the following **Risk Factors for Tuberculosis Disease:**
- diabetes mellitus
- lymphoma, leukemia or cancer of the head, neck or lung
- chronic kidney failure
- silicosis
- gastrectomy or jejuno-ileal bypass
- long term immunosupressive therapy
- greater than 10% below ideal body weight

⬭ **Section 4:** Check this box if, in the last five years, you have lived in or traveled for 30 days or more to any of the following **Areas with a High Prevalence of Tuberculosis** as defined by the World Health Organization and the state health department:
- **Africa –** All countries
- **Asia/Southeast Asia/Pacific Islands** – All countries
- **North, Central & South America** – Argentina, Bahamas, Belize, Bolivia, Brazil, Costa Rica, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
- **Europe** – Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova , Poland, Portugal, Romania, Russian Federations, Serbia, Slovak Republic, Slovenia, Ukraine, Yugoslavia
- **Middle East** – Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, Yemen

⬭ **No, none of the items listed in section 1 – 4 apply to me.**

_____ _____
Student Signature (Parent Signature if student<18) **Date**

_____ _____
Wilkins Wellness Center Official **Date**
rev. 6/08