Exam Date____________________
Resident or Commuter
Year________________________
Major________________________
SU ID# __________________
Rev. 2013 – office use only

Health and Insurance Requirements For Health Professions and Pharmacy Students

(Athletic Training, Nursing, Occupational Therapy, Pharmacy, Physical Therapy, Physician Assistant Studies, Respiratory Care, and Music Therapy)

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 include complete dates for month/day/year. 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: The athletic questionnaire must be submitted and mailed with this health form.

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 and signed by a Licensed Health Care Professional*)

Record complete dates (month/day/year) in chart below

IMMUNIZATIONS	Date of Immunization	Date of titer and results	
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
Varicella/ Chicken Pox (2 vaccination dates) or titer	1)	2)	N/A
Varicella /Chicken Pox Titer and results	N/A		N/A
Meningitis or waiver		N/A	N/A
Hepatitis B Series (3 dates) or waiver	1)	2)	3)
Hepatitis B Titer and results	N/A		N/A
Influenza vaccine		N/A	N/A

Two step tuberculosis tests: Two TST/TB skin tests are required with the second test being administered within 1-3 weeks from the first test. If you have annual testing for TST/TB due to employment or volunteer work, submit the last two annual dates and results. The annual test must be administered in the same month or before each year. If test has expired, a two step is required.

TB skin test (PPD/TST) #1 or Annual test: Date: __________ ________mm (induration)

TB skin test (PPD/TST) #2 or Annual test Date: __________ ________mm (induration)

Chest X-Ray Results (*if positive PPD*): Date: __________ Neg: ________ Pos: ________

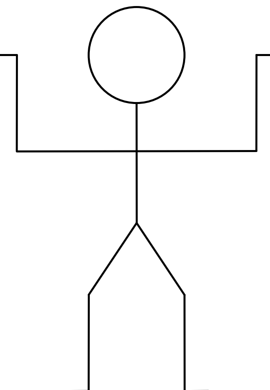
(A copy of the radiology report and/or treatment record is required)

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

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: ____

Acknowledgement Statement

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.

I understand that I must provide proof of current health insurance coverage (photocopy of insurance card or military identification card). 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 the 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: __________________________________