SHENANDOAH UNIVERSITY

Health and Insurance Requirements Form for All SU Students

Welcome to Shenandoah University!

All students attending Shenandoah University (SU) must submit a completed Health and Insurance Requirements Form (health form) to the Wilkins Wellness Center (WWC), along with documentation confirming a physical examination and all required immunizations and tests (unless an exemption has been granted by SU). The completed health form and supporting materials are due by May 15 for summer entry, August 1 for fall entry, and December 15 for spring entry.

Students admitted to "Health Care Programs" and all student-athletes are subject to additional program-specific requirements. Please review your admissions packet to determine your specific requirements or contact your program. All additional documentation should be uploaded through su.studenthealthportal.com.

Physical Examination, Immunization and Test Requirements

All incoming students must have:

- Physical examination (dated within 12 months of admission)
- Copy of current insurance card (front and back legible image)
- Two MMR (measles, mumps & rubella) vaccinations or a positive titer (blood test to prove immunity)
- Last date of the polio series or a positive titer
- Adult Tdap (tetanus, diphtheria & pertussis)(required within the past 10 years)
- Meningitis ACWY (last dose administered at age 16 or older)

Highly recommended vaccines:

- Covid19 and Influenza vaccines are encouraged each fall to maintain protection against currently circulating variants, reduce the risk of severe illness and support the health and continuity of the campus community.
- Meningitis B (serogroup B) - 2 doses separated by 6 months for undergraduates less than 24 years old

Medical or Religious Exemptions

Shenandoah University (SU) may grant a request for a medical or religious exemption for one or more of the above requirements. Students enrolled in Health Care Programs or any other program that requires clinical or experiential training, should be aware that if SU grants the student's request, it cannot guarantee SU will be able to secure the clinical/experiential assignments necessary for the student to graduate with a degree, or to obtain a licensed position in their field.

See https://www.su.edu/health-wellness/wilkins-wellness-center/health-forms/request-a-vaccine-exemption for more information.

Insurance Requirements

All students are required to have health insurance that complies with any applicable legal requirements (e.g., Affordable Care Act of 2010) and covers students in Virginia. Insurance documentation must be submitted on-line upon admission, and updated yearly, see https://www.su.edu/health-wellness/wilkins-wellness-center/health-insurance-requirements/

Please go to su.studenthealthportal.com to upload this form electronically.

1 Medical Consent & Emergency Contact Information

REQUIRED - All students

Date _____

Major _____

SU ID# _____

Rev 05/2026

Submit electronic form (document upload): su.studenthealthportal.com

Please do not mail or email your Health Forms. Uploads directly to the portal ensures proper HIPAA compliance.

Medical Consent Form/Emergency Contact Information

I hereby give permission to the WWC at SU to administer medical treatment to me, including treatment of minor illnesses, injuries, medical emergencies, and required or recommended immunizations. I also authorize SU to share my medical information with emergency medical personnel and/or medical facility personnel involved in my treatment when deemed necessary and in my best interest. Any disclosure or exchange of medical information will be made only in accordance with applicable law.

As a member of the SU community, I understand relevant health information that may affect my ability to participate in other areas such as athletics, clinical rotations, or my academic program may be communicated to appropriate parties in accordance with institutional policy and applicable law.

Student Signature: _____ Student Name (print) _____

Home Address: _____ ZIP: _____

City: _____ State: _____ Date of Birth: _____

Field of Study/Major: _____ Student's (cell) number: _____

Are you...(check all that apply):

Undergraduate ☐ *Graduate* ☐ *Athlete* ☐

Campus Resident ☐ *Commuter* ☐

Name of emergency contact person: _____

Address: _____ Relationship: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____

Mobile cell: _____

If the student is under the age of 18 years old:

I, _____ hereby represent that I am a parent with custodial rights, or the legal guardian, of the above named student and I give permission to SU to treat my child and for SU and Third Party Medical Professionals to share medical information about my child that they deem to be in the best interest of my child as further described above.

Parent/Legal Guardian Signature: _____ Date: _____

Please go to su.studenthealthportal.com to upload this form electronically.

2 Immunization & Tuberculosis Test History

REQUIRED - All students

Name: _____

_____

SU ID# _____

Date of Birth: _____

Immunization History

Record complete dates *(month/day/year)* in chart below. Form to be completed and signed by a Licensed Physician, Physician's Assistant or Nurse Practitioner. Documents proving that you had the required immunizations or titers **must** be included with your completed health form.

Immunization Record	Complete Date of Immunization *month/day/year*	Complete date of Immunization *(month/day/year)*	Complete date of Titer **Upload copy of results**
Measles, Mumps, Rubella vaccine (2 doses) **OR** Titer	1)	2)	Titer ___/___/___
Polio (last date in series only) **OR** Titer		**N/A**	Titer ___/___/___
Tetanus, Diphtheria, Pertussis (within the last 10 years)		**N/A**	**N/A**
Varicella/ Chicken Pox (2 doses) **OR** Titer	1)	2)	Titer ___/___/___
Meningitis B (serogroup B) 2 doses - Use same brand for both Penbraya or Trumenba **Highly recommended for all under-graduates through 23 years old**	1)	2)	**N/A**
Meningitis (A,C,W,Y)- Required 1 dose after age 16 yrs	1)	2)	**N/A**
Influenza (recommended)	1)	**N/A**	**N/A**
Covid19 (recommended)	1)	**N/A**	**N/A**
Hepatitis B (3 dose series) **OR**	1)	2)	3)
Hepli-sav (2 dose HepB series)	1)	2)	**N/A**
OR **Hepatitis B Titers - Upload Labs**			**N/A**
Surface Antibody (Anti-HBs)	Quantitative _____mIU/mL	Positive or Negative	Titer ___/___/___
Athletes only:			
Sickle Cell Trait Titer **(must upload lab results)**	Hgb S / hemoglobin solubility	Positive or Negative	Titer ___/___/___

*** Required for students in the **Health Care Programs**, recommended for all other students ***

Two-step tuberculosis tests: Two TB skin tests/readings. The first test/reading must be followed by a second test/reading between 7-21 days from the first READING. An annual test will be required thereafter. A Quantiferon –TB Gold test or T-spot can replace the two-step TB skin tests.

TB skin test (PPD/TST) #1: Date placed: _____ Date read: _____ mm (induration)

TBskintest (PPD/TST) #2: Date placed: _____ Date read: _____ mm (induration)

Quantiferon –TB Gold/T-Spot (**attach lab report**) Date: _____ Neg: _____ Pos: _____

If you have a positive TB test, exposure to TB or history of BCG vaccination you will need a chest X-ray and the Statement of Treatment Form (pg.6 of this packet) must be completed by your primary care provider.

Chest X-Ray Results : Date: _____ Neg: _____ Pos: _____ **(Attach radiology report)**

Health Care Provider (Print): _____ Signature: _____

Phone: _____ Date: _____

Please go to su.studenthealthportal.com to upload this form electronically.

3 Personal Health History

REQUIRED - All students

Name: _____

_____

SU ID# _____

Date of Birth: _____

Personal Health History

Allergies (Medication): _____

Allergies (Food): _____

Allergies (Environmental): _____

Allergies (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).
- ☐ HEADACHES/MIGRAINES.
- ☐ NEUROLOGICAL DISORDER (SEIZURES, MIGRAINES)
- ☐ VISUAL DIFFICULTIES
- ☐ RESPIRATORY DISEASE (INCLUDING ASTHMA / REACTIVE AIRWAY
- ☐ DISEASE). SKIN / DERMATOLOGICAL DISORDER
- ☐ CARDIAC DISORDER / HYPERTENSION / CHOLESTEROL
- ☐ GASTROINTESTINAL DISORDER
- ☐ MALE/FEMALE ISSUES
- ☐ LIVER DISEASE (I.E., HEPATITIS)
- ☐ DIABETES
- ☐ RENAL DISEASE (KIDNEY)
- ☐ CANCER
- ☐ IMMUNE SUPPRESSED
- ☐ OTHER

Explain any check marks above:

_____

_____

_____

_____

_____

_____

_____

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

Please go to su.studenthealthportal.com to upload this form electronically.

4 Physical Exam Form

REQUIRED FOR: Residential Undergraduates, Health Programs Students and Athletes

Name: _____

SU ID# _____

Date of Birth: _____

Physical Exam

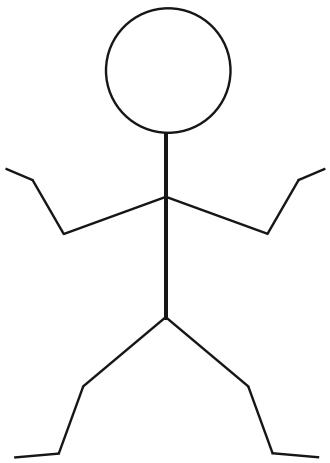
Vital Signs: Ht _____ Wt _____ BP _____ Pulse _____ Temp _____ LMP _____ BMI _____

Vision: OD _____ OS _____ OU _____ Rx Lenses *(circle one)*: Yes or No Contact Lenses *(circle one)* : Yes or No

Physical Examination	Normal	Abnormal	Notes
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.

Deep Tendon Reflexes:



Additional Comments: _____

Health Care Provider (Print): _____ Signature: _____

Phone: _____ Date: _____

Please go to su.studenthealthportal.com to upload this form electronically.

5 Wilkins Wellness Center Tuberculosis Risk Assessment Form

REQUIRED FOR: All students

Name: _____

_____

SU ID#_____

Date of Birth:_____

Required for all students attending Shenandoah University

IF YOU CHECK ONE OF THE BOXES IN SECTIONS 1 – 4, YOU ARE REQUIRED TO HAVE A TUBERCULOSIS (PPD) SKIN TEST. If you are under 18 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 Risk Factors for Tuberculosis Infection:**

- 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 or bloody sputumn

☐ **Section 2: Check this box if you have any of the following Risk Factors for Tuberculosis Infection:**

- Use of illegal injected drugs
- HIV (Human Immunodeficiency Virus) infection
- Health Care Worker currently employed in a high-risk hospital setting
- Resident or employee in a congregate living setting (nursing home, homeless shelter, correctional facility)
- Close contact with a known case of active tuberculosis

☐ **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, or chronic kidney failure
- Silicosis
- Long-term immunosupressive therapy
- Greater than 10% below ideal body weight

☐ **Section 4:** Check this box if you have lived in or traveled for 90 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, Belize, Bolivia, Brazil, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
- Europe – Belarus, Bosnia-Herzegovina, Bulgaria, Latvia, Lithuania, Macedonia, Moldova, Portugal, Romania, Russia Federations, Serbia, Ukraine
- Middle East – Iraq, Kuwait, Qatar, Yemen

☐ **None of the items listed in section 1 – 4 apply to me.**

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

Wilkins Wellness Center Staff Member:_____ Date: _____

Please go to su.studenthealthportal.com to upload this form electronically.

6 Wilkins Wellness Center Tuberculosis Statement of Treatment

Name: _____

_____

SU ID#_____

Date of Birth:_____

Complete this page **ONLY** if you have had a positive TB test, exposure or BCG vaccination.
Please submit a chest x-ray report dated within 12 months of your matriculation date and this page completed and signed by your primary care provider.

Dear Provider,

Your patient, _____ date of birth: _____will be providing direct patient care to comply with the clinical experience requirements. See attached chest x-ray documentation.

Free of Active Disease or Determined to have Latent TB

☐ My patient, named above, has been examined for Pulmonary Tuberculosis (TB) and is free of active disease. The patient has been counseled on the risk of developing Pulmonary TB and risks that the patient may pose to their contacts. The patient has been instructed on signs and symptoms of Pulmonary TB and to seek medical evaluation should they become symptomatic.

Placed on Treatment Therapy for Latent TB: No_____ Yes _____ Rx: _____

Follow-up appointment date: _____

Return to school/clinical status: **May** return to full duty as of (date):_____

Current Diagnosis of Active Disease

☐ Placed on Treatment Therapy: No _____Yes _____ Rx: _____

Follow-up appointment date:_____

Return to school/clinical status: **May not** return to school/clinical at this time due to current diagnosis of "active Tuberculosis." _____

Treatment of Active Disease

☐ I attest that I am a health care provider qualified to make the determination that this patient is no longer infectious by demonstrating sputum is free of bacilli on three (3) consecutive smears on separate days or sputum cultures show no growth.

Return to school/clinical status: **May** return to school/clinical full duty as of (date): _____

Comments: _____

_____

Provider Signature (MD/DO, NP, PA):_____ Date: _____

Health Care Provider (Print Name): _____

Phone: _____

Address: _____