Year_____
Major_____
SU ID# _____
Com ___ Rec___ EM___
Rev. 2017/R 2 (office use only)

Health and Insurance Requirements For General Admissions Students

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

Mail to: Wilkins Wellness Center, 1460 University Drive, Winchester, Virginia 22601
Phone: (540) 665-4530

Original forms must be mailed. Faxed and emailed 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. 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 must be mailed or delivered in person and received by the Wilkins Wellness Center prior to the due date. It is your responsibility to meet any additional requirements mandated by your program major.

Student athletes: Sickle Cell Trait blood test must be submitted with this 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 as needed. I give the hospital or emergency medical personnel permission to release information to the Wilkins Wellness Center staff as needed. 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 _____

Home Address: _____ City: _____ State: ____Zip:_____

Field of Study/Major: _____ SU Athlete: Yes or No (circle)

Graduate or Undergraduate: _____ Campus Resident or Commuter: (circle)

Email address: _____ Student's (cell) number: _____

SS# _____ Date of Birth _____

Emergency Contact Person: _____ Relationship: _____

Address: _____City:_____ State: _____Zip:_____

Home Phone: _____ Mobile: _____

******Parent's signature if the student is under the age of 18 years old. _____**

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

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

(To be completed and signed by a Licensed Health Care Professional

IMMUNIZATIONS The chart must be filled in or the record will not be accepted.	Complete date Month/day/year	Date of titer and results (attach copy of lab report)	
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) within the last 10 years		N/A	N/A
Meningitis (A,C,Y,W) within last 5 years or a signed waiver		N/A	N/A
Meningitis B	1)	2)	3)
Hepatitis B Series (3 dates) or waiver (See page 4 for waiver)	1)	2)	3)

TB assessment (See page 5 for assessment form) **Date: _____ (If high risk on assessment sheet, a TST/TB skin test is required)**

TB skin test (PPD/TST): **Date placed: _____ Date read: _____ _____mm (induration)**

QuantiFERON –TB Gold if a positive assessment **Date: _____ Neg: _____ Pos: _____**

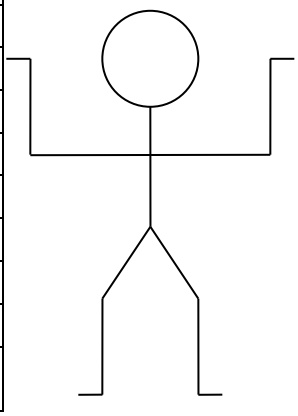
Chest X-Ray Results *(if a previous positive PPD)*: **Date: _____ Neg: _____ Pos: _____ (attach radiology/TX report)**
within the last 12 months.

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: _____ SU 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 have health insurance coverage and must maintain healthcare insurance throughout all academic and clinical years. Students who have private insurance through their parents, spouse, partner or personal policy are required to impute their insurance information annually online at www.gallagherstudent.com/SU.

<u>Students who do not have insurance can enroll in the student plan at www.gallagherstudent.com/SU.</u>

International and domestic insurance policies must meet the 2010 Affordable Healthcare Act regulations.

International travel polices are not accepted.

Religious Waiver Policy

All students admitted to the School of Nursing and Division of Respiratory Care, School of Pharmacy, School of Health Professions (Physician Assistant Studies, Physical Therapy, Occupational Therapy, and Athletic Training) (collectively, "Health Professions") and Music Therapy must provide evidence of specific immunizations prior to the applicable date set forth on the Health and Insurance Requirements for Health Professions Students form. Students who fail to provide these documents before the deadline may have their admission revoked, or be suspended or dismissed from SU, and will not be allowed to attend classes, laboratory sessions, or clinical rotations. As a result of public health considerations, students admitted to a Health Professions program are not eligible for a Religious Exemption to the immunization requirements.

Name: _____ SU 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 _____ SU 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.** ***If high risk on assessment sheet, a TST/TB skin test* or QuantiFERON –TB Gold if a positive assessment *is required*.**

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

_____ _____
Wilkins Wellness Center Official **Date**
rev. 2015