Year__________________

Major_________________

SU ID# ________________

Com ___ Rec___ EM___

Rev. 2017 R2 (office use

Health and Insurance Requirements For Health Professions Students

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

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

Original forms must be mailed. Faxed copies and emailed 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 academic program especially if you declare a Religious Waiver.

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 _________________________

Name of 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.	Date of Immunization month/day/year	Date of titer and results (Attach copy of lab report) if no vaccination dates	
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
Varicella/ Chicken Pox (2 vaccination dates) or titer (Date of disease is not acceptable)	1)	2)	N/A
Varicella /Chicken Pox Titer and results	N/A		N/A
Meningitis (A,C,YW) or waiver within last 5 years		N/A	N/A
Meningitis B	1)	2)	3)
Hepatitis B Series (3 dates) or waiver (See page 4 for 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/readings. The first test/ reading must be followed by a second test/reading between 7-21 days from the first test per our clinical contract. This is regardless of prior or current testing so that all students will be on the same academic schedule. An annual test will be required thereafter. A QuantiFERON –TB Gold blood test can replace the two-step TB skin tests.**

TB skin test (PPD/TST) #1: Date placed: __________ Date read: _______________ ________mm (induration)

TB skin test (PPD/TST) #2: Date placed: __________ Date read: _______________ ________mm (induration)

QuantiFERON –TB Gold Date: _________---_ Neg: ________ Pos: ________

Chest X-Ray Results *(if positive PPD) within the last 12 month)*: Date: __________ Neg: ________ Pos: ________ (Attach radiology report)

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)

_____ Headaches/Migraines

_____ Neurological Disorder (seizures, migraines)

_____ Visual Difficulties

_____ Respiratory Disease (including asthma / Reactive Airway Disease)

_____ Cardiac Disorder / Hypertension / Cholesterol

_____ Gastrointestinal Disorder

_____ Male/Female issues

_____ Liver Disease (i.e., Hepatitis)

_____ Diabetes

_____ Renal Disease (Kidney)

_____ Cancer

_____ Skin / Dermatological Disorder

_____ Immune suppressed

_____ Other

Explain any check marks above: ____

Health Insurance Information

Students are required 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. Students who do not have insurance can enroll in the student plan at www.gallagherstudent.com/SU.

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: __________________________________