SHENANDOAH UNIVERSITY HEALTH FORM

Welcome to Shenandoah University.

This cover letter is to help clarify the immunization and testing requirements for our Health Professions Programs.

All students admitted to Shenandoah University (SU) 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") 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, 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.

A paper copy of all immunizations and tests must be submitted with the health form. Dates must be recorded in the box on page 2. If the provider writes in the box "see attached," the document will be returned to the sender. The health form must be mailed or personally delivered. Faxes and scanned copies will not be accepted. Please ensure your SU student ID number is on each page of the document and keep a copy of the document for yourself.

Requirements:

- Physical examination
- 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) within the past 10 years regardless of last Tdap vaccination
- Two Varicella (chicken pox) vaccinations or a positive titer
- Meningitis ACYW135 within the past 5 years or waiver
- Two meningitis B vaccinations (dates depends on manufacturer) or waiver
- Three hepatitis B vaccinations or a positive titer or waiver
- Current influenza vaccination after August 1st for the current flu and academic year
- Two TB skin tests and two readings with the second test and reading 7-21 days from the first test OR QuantiFERON TB Gold test within the last 12 months
- A Positive TB skin test from an exposure, latent TB or BCG vaccination requires that the student complete a chest x-ray and Statement of Treatment form (included on page 5 of the health form) "within" the last 12 months and must be signed by a MD/DO, NP or PA. Radiological report and

Insurance:

All students are required to have health insurance that meets the current Affordable Care Act of 2010 and covers students in the state of Virginia. Medicaid from Virginia, West Virginia, Maryland, and the District of Columbia are the only Medicaid policies accepted. Insurance documentation must be completed online upon admission and updated yearly by August 1st at www.gallagherstudent.com/SU.

This cover letter does not need to be submitted with the health form.

Wilkins Wellness Center Staff

SHENANDOAH UNIVERSITY

Year_____

Major_____

SU ID# _____

Com ___ Rec___ EM___

Rev. 2018 (office use only)

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 and emailed copies will not be accepted.

All students are required to have a completed health form on file. All immunizations or tests must include complete dates for month/day/year. *A copy of all immunizations or tests must be included with your submission*. 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.

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 may discuss information about my health which might affect my participation in team sports with the Athletics Department.

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 (mobile) number:_____

SS#: _____ Date of Birth: _____

Name of emergency contact person: _____ Relationship: _____

Address: _____City:_____ State: _____Zip:_____

Home Phone: _____ Mobile: _____

****Parent's signature if 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)

Hard copy of documented immunizations or titers must be attached to support this record.

IMMUNIZATIONS This chart must be completed or the record will not be accepted.	Complete date of Immunization month/day/year	Complete 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
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,Y,W135) or waiver within last 5 years		N/A	N/A
Meningitis B series	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 (after August 1st of current year)		N/A	N/A
Sickle Cell Trait Titer (Athletes only) – please circle results	Positive	Negative	N/A

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 test per 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 may replace the two-step TB skin tests.

NOTE: T-Spot blood tests are not acceptable.

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 months*: Date: _____ Neg: _____ Pos: _____ (Attach radiology report)

If you have a positive test result (exposure or BCG vaccination) and a chest x-ray was ordered, the Statement of Treatment form must be completed by your primary care provider. The form is on page 5.

Health Care Provider: (Print name) _____ **Signature:** _____

Phone#:_____ **Date:** _____

Religious Waiver Policy

All students admitted to Shenandoah University (SU) 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, 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:** _____

PERSONAL HEALTH HISTORY

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**

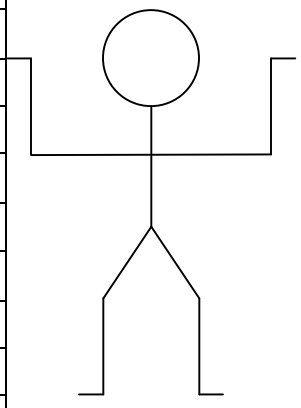
Explain any check marks above: _____

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:** _____

Shenandoah University Immunization Waiver Form

Meningococcal Vaccine ACYW135 or B 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 information from The Centers for Disease Control and Prevention (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 be vaccinated.

By my signature below, I certify, 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 if you do not want your child to be vaccinated.

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

Printed name of parent/guardian: _____ **Date:** _____

Signature of parent/guardian: _____

Hepatitis B Vaccination Waiver

Virginia Law 23-7.5 requires that all students be vaccinated with the Hepatitis B vaccine or sign a waiver declining the vaccination series. In order to make an informed decision regarding immunization against Hepatitis B disease, please read the 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, I choose not to be vaccinated against Hepatitis B 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** _____ **certify, I choose not to have my child,** _____**, vaccinated against Hepatitis B disease.**

Printed name of parent/guardian: _____ **Date:** _____

Signature of parent/guardian: _____

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

Shenandoah University
Wilkins Wellness Center
Tuberculosis-Statement of Treatment

Dear Provider,

Your patient, _____, date of birth: _____ will be providing direct patient care to comply with the clinical experience requirements. A chest x-ray was completed on _____/_____/_____ due to a Tuberculin Skin Test result measuring: _____ mm. (See attached CXR)

☐

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: _____

_____ **May return to full duty as of:**
_____ ***Date***

☐

Placed on Treatment Therapy: _____ **No** _____ **Yes** **Rx:** _____

Follow-up appointment date: _____

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

☐

by demonstrating sputum is free of bacilli on three (3) consecutive smears on separate days or

_____ **May return to school/clinical full duty as of:** _____ ***Date***

Comments:

_____

_____

Provider signature (MD/DO, NP, PA) **Date**

Provider printed name, address, and phone number