SHENANDOAH UNIVERSITY HEALTH FORM

Welcome to Shenandoah University.

This cover letter is to help clarify the immunization and testing requirements for Shenandoah University (SU) students.

All students admitted to SU must provide evidence of specific immunizations prior to the applicable date set forth on the Health and Insurance Requirements form. In addition, all Health Profession students must provide additional immunizations and testing required for clinicals. 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 and supporting documentation must be attached. 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.

- 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 (Td will not be accepted)
- **Two Varicella (chicken pox) vaccinations or a positive titer (date of disease not acceptable) *****
- Meningitis ACYW135 within the past 5 years or waiver on page 5
- Two meningitis B vaccinations (dates depend on manufacturer) or waiver on page 5
- **Three hepatitis B vaccinations or a positive titer or waiver on page 5 *****
- **Current flu vaccination after September 1st for the current flu season/academic year and due by October 15th *****
- **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 documented on page 3 (T-spot not accepted) *****
- 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 7 of the health form) "within" the last 12 months and must be signed by a MD/DO, NP or PA. Radiological report and Statement of Treatment form on page 7 must be submitted with the health form to the Wellness Center.

***** Required for Health Profession majors**

Insurance requirements:
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. Insurance documentation must be completed online upon admission and updated yearly by August 1st at www.firststudent.com.

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. 2019 (office use only)

Health and Insurance Requirements for all students

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 ("WWC") at Shenandoah University for its staff to administer medical treatment to me or my minor child, including treatment of minor illness, injuries, medical emergencies, and required or recommended immunizations. I also authorize WWC staff to share my contact information (including email and/or physical address and phone number) and medical information (including health insurance information) with any hospital, treatment center, laboratory or emergency medical personnel (the "Third Party Providers") as they may deem necessary. I give the Third Party Providers permission to release any information about me or my minor child to the WWC staff they may deem necessary. I understand that the WWC staff may disclose information about my (or my minor child's) health to other school officials for legitimate educational purposes, including issues that 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 (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) within last 5 years or waiver on page 5		N/A	N/A
Meningitis B series or waiver on page 5	1)	2)	3)
***** Hepatitis B Series (3 dates) or waiver on page 5**	1)	2)	3)
Hepatitis B Titer and results	N/A		N/A
***** Influenza vaccine (after September 1st of current year but due by October 15th each year enrolled)**		N/A	N/A
Sickle Cell Trait Titer (Athletes only) – please circle results and attach lab results	Positive	Negative	N/A

TB Assessment (non-health profession students on page 6) Date: _____ Negative _____ Positive _____

*** Required for Health Profession majors

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 #**_____

Tuberculosis Testing ***

Tuberculosis testing is required for all health professions students annually. You must complete to meet the clinical requirements:

- **Two negative TB skin tests with the second test being within 7-21 days from the first test (OR) a negative TB QuantiFERON Gold with results attached to the health form. Complete documentation below.**

- **If a positive TB skin test or history of exposure, latent TB or BCG vaccination, the student is required to provide chest x-ray radiology report within the last 12 months and a signed Statement of Treatment form. (See page 6 attached). The Statement of Treatment form must be signed by an MD/DO, NP, or PA. The radiology report and Statement of Treatment form must be submitted with the health form to the Wilkins Wellness Center.**

- **T-Spot is not accepted per clinical contract.**

First TB skin test

PPD administered on date_____ **Read date**_____

Please circle test results **Negative.** **or** **Positive** **Size of induration**_____

RN, NP, PA, or MD Signature_____**Date**_____

Second TB skin test with 7-21 days from first test

PPD administered on date_____ **Read date**_____

Please circle test results **Negative.** **or** **Positive** **Size of induration**_____

RN, NP, PA, or MD signature_____ **Date**_____

QuantiFERON TB Gold blood test
(can replace the two TB skin tests)

Tb QuantiFERON Gold date _____**Results**_____
Attached copy of the lab results.

RN, NP, PA, or MD signature_____ **Date** _____

Note: If positive TB testing results are positive, a student must have a chest x-ray within last 12 months, submit the radiology report, and medically signed Statement of Treatment form (page 7) required.

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:

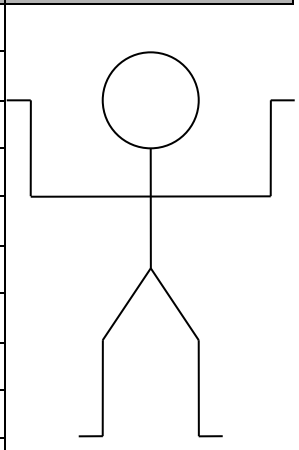
_____	**Psychiatric Disorder (including anxiety / depression)**	_____	**Liver Disease (i.e., Hepatitis)**
_____	**Headaches/Migraines**	_____	**Diabetes**
_____	**Neurological Disorder (seizures, migraines)**	_____	**Renal Disease (Kidney)**
_____	**Visual Difficulties**	_____	**Cancer**
_____	**Respiratory 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: _____

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: _____

Wilkins Wellness Center
Tuberculosis Risk Assessment Form
Required for Non-health profession students

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 currently employed in a high-risk hospital setting
- 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.**

_____ _____

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

_____ _____

Wilkins Wellness Center Official **Date**

rev. 2019

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)

☐ ***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 healthcare 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

Provider printed name, address, and phone number