Welcome to Shenandoah University!

The purpose of this welcome letter is to clarify: (i) the physical examination, immunization, testing and health insurance requirements for all students attending Shenandoah University (“SU”) and (ii) the students’ obligation to submit to the Wilkins Wellness Center (“WWC”) on a timely basis, a fully completed Health and Insurance Requirements Form (the ‘health form”) and appropriate supporting documentation. As noted below, students in our nursing, pharmacy or health professions schools, or in our music therapy program (collectively, the “Health Care Programs”) require immunizations and tests in addition to those required of students in other schools/programs.

**Physical Examination, Immunization and Test Requirements**

All incoming students must have completed a physical examination within the previous 12 months and received the immunizations and tests listed below (or been granted an exemption by SU) prior to the due dates set forth on the health form.

- Physical examination (incoming students only)
- COVID-19 vaccination (as per Shenandoah University requirements)
- 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 last 10 years regardless of last Tdap vaccination
- Two Varicella (chicken pox) vaccinations or a positive titer***
- Meningitis ACWY within the last 5 years – or sign waiver
- Two or three meningitis B vaccinations (dates depend on manufacturer) – or sign waiver
- Three hepatitis B vaccinations or a positive titer *** – or sign waiver
- Current influenza vaccination after August 1 for 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 or T-spot within the last year***
- Positive TB skin test from an exposure, latent TB or BCG vaccination, the radiology report for a chest x-ray with the last 12 months and Statement of Treatment Form (included) signed by a MD/DO, NP or PA. Radiological report and Statement of Treatment Form on page 4 must be submitted with the health form***
- Sickle Cell Trait blood test (Athletes only)

(*** Required only for students in the Health Care Programs)

**Exemptions**

Shenandoah University (“SU”) may grant medical or religious exemptions to one or more of the above requirements, although students in the Health Care Programs or any other SU program that requires clinical or experiential training, including without limitation music therapy (“Clinical/Experiential Programs”), 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. In addition, SU may, in its discretion, make the student responsible for securing clinical/experiential assignments at clinical/experiential sites acceptable to their program.

See [https://www.su.edu/health-wellness/wilkins-wellness-center/health-forms/request-a-vaccine-exemption](https://www.su.edu/health-wellness/wilkins-wellness-center/health-forms/request-a-vaccine-exemption) for more information.
Completed Health Form and Supporting Documentation

A completed health form, with documentation confirming a student has completed a physical examination and received all required immunizations and tests (or been granted an exemption by SU) must be provided to WWC no later than June 1 for students starting in the summer, August 1 for students starting in the fall, and by December 15 for students starting in the spring.

The completed health form and supporting documentation must be mailed or personally delivered. Please ensure your SU student ID number is on each page of the completed health form and keep a copy of your completed health form and supporting documentation for your records.

Insurance requirements

All students are required to have health insurance which complies with any applicable legal requirements (e.g., Affordable Care Act of 2010) and covers students in the state of Virginia. Insurance documentation must be submitted online upon admission, and updated yearly, by August 1, at firststudent.com.

A copy of this letter does not need to be submitted with the completed health form.

Sincerely,

The Wilkins Wellness Center Staff
(540) 665-4530
Health and Insurance Requirements
Form for All SU Students

A completed health form and supporting documentation must be mailed or delivered in person so that they are received on or prior to the due dates noted below.

Mail to: Wilkins Wellness Center, 1460 University Drive, Winchester, Virginia 22601
If delivering in person, the WWC is in Racey Hall on L.P. Hill Drive

All students are required to have a completed health form on file with the WWC. All immunizations or tests must include complete dates for month/day/year. A hard copy of the immunizations or tests must be included with your submission. This form must be completed and returned by June 1 for the summer semester, August 1 for the fall semester, and December 15 for the spring semester. The original health form must be mailed or delivered in person and received by the WWC prior to the due date. It is your responsibility to meet any additional requirements mandated by your academic program.

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 illness, injuries, medical emergencies, and required or recommended immunizations. I also grant consent to SU to share any of my medical information in its possession with any emergency medical and/or medical facility personnel treating me (“Third-Party Medical Personnel”) that SU deems to be in my best interest. In addition, I also grant consent to any Third-Party Medical Personnel to share any of my medical information in their possession with SU that such Third-Party Medical Personnel deems to be in my best interest. If I am a member of, or trying out for, a SU athletic team, I understand that WWC staff will discuss with the Athletics Department information about my health which might affect my ability to participate on a SU athletic team.

Student Signature: ___________________________ Student Name (Print): ___________________________

Home Address: _____________________________________________________________
City: ___________________________ State: ___________________________ Zip: ___________________________

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

Graduate or Undergraduate (circle one)  |  Campus Resident or Commuter (circle one)

Email address: ___________________________ Student’s (cell) number: ___________________________

SS#: ___________________________ Date of Birth: ___________________________

Name of emergency contact person: ___________________________ Relationship: ___________________________

Address: _____________________________________________________________
City: ___________________________ State: ___________________________ Zip: ___________________________

Home Phone: ___________________________ Mobile: ___________________________

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: ___________________________
### 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.

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Complete Date of Immunization</th>
<th>Complete date of titer and results</th>
<th>Manufacturer</th>
<th>(required for Covid 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COV ID-19 vaccine #1</td>
<td>N/A</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>COVID-19 vaccine #2</td>
<td>N/A</td>
<td></td>
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<tr>
<td>Measles, Mumps Rubella vaccine #1</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps Rubella vaccine #2</td>
<td>N/A</td>
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<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Polio (last date in series only)</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Tetanus, Diphtheria, Pertussis (Adult) within the last 10 years</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Varicella/Chicken Pox (2 vaccination dates) or titer*** (Date of disease is not acceptable)</td>
<td>1)</td>
<td>2)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Varicella/Chicken Pox Titer and results***</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Meningitis (ACWY)</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Meningitis B</td>
<td>1)</td>
<td>2)</td>
<td>3)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Series (3 dates)</td>
<td>1)</td>
<td>2)</td>
<td>3)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Titer and results</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Influenza vaccine (after August 1 for fall semester)***</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Trait Titer (Athletes only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

***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 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 or T-Spot 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/T-Spot (attach lab report): 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 (exposure or BCG vaccination) and a chest x-ray is ordered, the Statement of Treatment Form must be completed by your primary care provider. The form is on page 6.

Health Care Provider (Print): ________________________________ Signature: ________________________________
Phone: ________________________________ Date: ________________________________

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) ☐ Male/Female issues
☐ Headaches/Migraines ☐ Liver Disease (i.e., Hepatitis)
☐ Neurological Disorder (seizures, migraines) ☐ Diabetes
☐ Visual Difficulties ☐ Renal Disease (Kidney)
☐ Respiratory Disease (including asthma / Reactive Airway Disease) ☐ Cancer
☐ Skin / Dermatological Disorder ☐ Immune suppressed
☐ Cardiac Disorder / Hypertension / Cholesterol ☐ Other
☐ Gastrointestinal Disorder

Explain any check marks above: ______________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

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
<table>
<thead>
<tr>
<th>Physical Examination</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
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<tr>
<td>Cardiovascular</td>
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<td></td>
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<tr>
<td>Gastrointestinal</td>
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<td></td>
<td></td>
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<tr>
<td>Genitourinary (testicles) *</td>
<td></td>
<td>Glucose _____</td>
<td>Protein _____</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood _____</td>
<td>Leuk _____</td>
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<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Metabolic/Endocrine</td>
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<td></td>
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<tr>
<td>Derm</td>
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<tr>
<td>Lymph</td>
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<td></td>
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<tr>
<td>Neuro / Psychiatric</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Testicle exam required for men participating in sports.

Deep Tendon Reflexes:

Additional Comments: ________________________________

____________________________

____________________________

____________________________

____________________________

____________________________

Health Care Provider (Print): ______________________  Signature: ______________________

Phone: ________________________________  Date: ______________________
Wilkins Wellness Center
Tuberculosis Risk Assessment Form

Required for students in schools or programs other than Health Care Programs

The Centers for Disease Control and Prevention and the United States 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 immunosuppressive 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, Russian Federations, Serbia, Ukraine
  - Middle East – Iraq, Kuwait, Qatar, Yemen

☐ No, none of the items listed in section 1 – 4 apply to me.

Student Signature (Parent Signature if student<18): ___________________________ Date: __________________

Wilkins Wellness Staff Member: ___________________________ Date: __________________
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 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: ____________________________