University of Mary Washington
1301 College Avenue, Fredericksburg VA 22401
Student Health Center – Lee Hall 112
Phone 540-654-1040, FAX 540-654-1077
www.students.umw.edu/healthcenter

Health History

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Virginia State law (§ 23-7.5) requires that all full-time students enrolled for the first time in a four-year public institution of higher education in the Commonwealth submit a health history. This form satisfies that requirement. The Student Health Center (**SHC**) does not require a physical examination but it does require a visit to your health provider for immunization records and verification with a signature. This document is an editable PDF, that is, for most information areas you may type on the form rather than handwrite.

Please keep a copy for your records and send the **ORIGINAL,** with signatures, to:

University of Mary Washington
Student Health Center
1301 College Avenue
Fredericksburg, VA 22401

This form is due **AUGUST 1st** for the Fall Term
or **JANUARY 3rd** for the Spring Term.

If you fail to submit this form you will be unable to register for the following semester.

General Information

Student Name: _____ Entering Semester/Year: _____
Last First MI

What is your preferred name, that is, how do you wish to be addressed? _____

Birth Date: _____ Age: _____ UMW email: _____

Gender Identity: ☐ Man ☐ Woman ☐ Transgender ☐ Self Identify: _____

Parent(s) or Guardian: _____

Full Home Address: _____
number and street city state zip

Phone Numbers: Home: _____ Cell: _____ Father: _____ Mother: _____

Citizenship: ☐ U.S. ☐ Other: _____

Country of birth if not U.S.: _____ year entered US: _____

Health Insurance

Do you have health insurance? ☐ Yes ☐ No If yes, which insurance? _____ ☐ HMO ☐ PPO ☐ POS

Please attach a copy of your health insurance card. While the SHC does not bill insurance, your card tells us where we can send you for lab and x-ray and who we can send you to for referrals. This also serves as a backup copy should you not be able to find yours in an emergency.

Please check to see if your insurance allows referrals in our area. Out-of-state students may find their medical insurance is not accepted in Virginia.

Kaiser insurance does not allow us to order lab or x-rays nor can we refer you to local providers. If you have Kaiser insurance you should go to the local Kaiser medical office for your care. It is located nearby at 1201 Hospital Drive, Fredericksburg VA 22401 (540) 368-3700.

Similarly, we cannot order lab or x-rays nor can we make referrals for Tricare Prime or other HMO patients.

Emergency Contact Information – In the event of an emergency, I give the SHC permission to contact:

Name: _____ Relationship: _____

Phone Numbers: _____

Minor Consent – Complete only if the student is under 18 years of age at time of enrollment.

The SHC needs written parental or legal guardian permission to provide medical care to minors.

"I grant permission to the University of Mary Washington Health Center Physician and Staff to provide or secure medical treatment/care as needed for my son/daughter. In the event of a medical or surgical emergency I understand that every effort will be made to contact me prior to treatment, provided that doing so would not further jeopardize my child's health or life."

Signature of Parent or Guardian: _____ Date: _____

Printed name of Parent or Guardian: _____ Relationship: _____

Version date: June 9, 2015

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Health History

Student Name:

Family Medical History – Please explain any YES answers below.

Any family members who died suddenly before the age of 50? ☒ No ☐ Yes _____

Any family members with blood clots? ☒ No ☐ Yes _____

Father: ☐ Good health ☐ No, please explain _____

Mother: ☐ Good health ☐ No, please explain _____

Brothers: ☐ Good health ☐ No, please explain _____

Sisters: ☐ Good health ☐ No, please explain _____

Personal Medical History – Please answer all questions and explain any yes answers below.

Do you have or have you had any …

Medical problems? ☐ No ☐ Yes _____

Mental health issues? ☐ No ☐ Yes _____

Drug **allergies** or **intolerance**? ☐ No ☐ Yes _____

Any other **allergies?** ☐ No ☐ Yes _____

Any **serious injuries** or **concussions**? ☐ No ☐ Yes _____

Do you wear **glasses** or **contacts**? ☐ No ☐ Yes _____

Have you ever had **surgery**? ☐ No ☐ Yes _____

Have you ever been a patient in the **hospital**? ☐ No ☐ Yes _____

Do you have any **disabilities**? ☐ No ☐ Yes _____

Have you ever had **mononucleosis?** ☐ No ☐ Yes _____

Do you see any **specialists**? ☐ No ☐ Yes _____

Do you have any **diet** restrictions? ☐ No ☐ Yes _____

Do you take any **supplements**? ☐ No ☐ Yes _____

Do you take any **medications?** ☐ No ☐ Yes _____

Is there anything else we should know? ☐ No ☐ Yes _____

Check List – Before submitting this form please check for the following:

- Have your health provider review and sign your immunization and tuberculosis forms.
- Complete your health history and mail all original forms to us with a copy of your insurance card.
- Keep a copy of all forms for your records, in particular the immunization record.
- Put your insurance card in your wallet.
- If applicable, have a parent or guardian sign the minor consent form.

We understand that it is not always possible to go to your health provider before the forms are due and we don't want to make this a burden for you or us. You may submit an official electronic medical record printout of your immunizations for us to review. You may also come to the SHC when you arrive on campus and our nurses will be happy to review your forms, immunizations and tuberculosis screening and guide you through the process. Please don't ignore these forms. They are required by state law and you will be blocked from second semester registration if they are not completed.

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UMW Immunization Record

Student Name: Date of Birth:

All full-time students are required by the Code of Virginia (Section 23-7.5) to provide documentation of their immunizations by a health care professional (MD, DO, NP, PA or RN). Alternatively, you may submit an electronic medical record printout or other official copy of your immunizations. If you are unable to provide documentation, then vaccines may be repeated. If you are a foreign student, the documentation needs to be translated into English.

Required Vaccinations – You will not be allowed to enroll without documentation.

Tetanus Diphtheria ☐ **TD** or ☐ **Tdap** within the past ten years Date: _____

Mumps, Measles and Rubella ☐ **MMR** - 2 doses required **on or after first birthday** and at least 28 days apart

Date 1: _____ Date 2: _____

or ☐ attach lab results confirming immunity

Polio (OPV/IPV) ☐ **Polio** - Primary series with **last dose given after age 4**

Date 1: _____ Date 2: _____ Date 3: _____ Date 4: _____

or ☐ attach lab results confirming immunity

If an adult booster was given after age 18 Date 5: _____

Highly Recommended Vaccinations – You must provide dates of vaccination or sign a waiver.

Hepatitis B ☐ **3 doses**

Date 1: _____ Date 2: _____ Date 3: _____

or ☐ attach a copy of your lab results confirming immunity

or ☐ sign this waiver after reading the attached information about Hepatitis B vaccination.

I have reviewed the information on the second page of this form on the risk associated with hepatitis B disease, availability and effectiveness of any vaccine against hepatitis B disease, and I choose not to be vaccinated against hepatitis B disease.

_____ _____
Signature Date

Meningitis ☐ **Meningococcal Quadrivalent –** Vaccine given **on or after 16th birthday** Date: _____

or ☐ sign this waiver after reading the attached information about meningitis vaccination.

I have reviewed the information on the second page of this form on the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease, and I choose not to be vaccinated.

_____ _____
Signature Date

Recommended Vaccinations – We recommend these vaccinations but they are not required.

Hepatitis A ☐ 2 doses Date 1: _____ Date 2: _____

HPV (Genital wart vaccine) ☐ 3 doses Date 1: _____ Date 2: _____ Date 3: _____

Varicella (Chicken pox) ☐ 2 doses Date 1: _____ Date 2: _____

or ☐ attach a copy of your lab results confirming immunity

or ☐ date of the disease: _____

Your health care provider must sign here to verify review of your vaccinations.

_____ _____ (_____)_____
Signature of Health Care Provider **Date** **Phone Number**

Medical Exemption

As specified in Section 22.1-271.2C(II) of the code, I certify that administration of the vaccines designated above would be detrimental to this student's health. The vaccines(s) is (are) specifically contraindicated because _____

This contraindication is ☐ permanent (or) ☐ temporary and expected to preclude immunization until _____

Your health care provider must sign here to verify this medical Exemption.

_____ _____ (_____)_____

Signature of Health Care Provider **Date** **Phone Number**

Religious Exemption

Any student who objects on the grounds that administration of immunizing agents conflicts with his or her religious tenets or practices shall be exempt from the immunization requirements unless an emergency or epidemic of disease has been declared by the Board of Health. An affidavit of religious exemption must be submitted on a Certificate of Religious Exemption (Form CRE-1) which may be obtained at any local health department, school division superintendent's office, or local department of social services, or you may obtain a VA religious Exemption Form from **http://www.vdh.state.va.us/epidemiology/immunization/documents/cre_1.pdf.**

Hepatitis B

Hepatitis B is a potentially fatal viral liver infection spread from person to person by contact with blood and body fluids. Most commonly this is through unprotected sex or by sharing infected needles when using illegal drugs. Hepatitis B may cause an acute, short-term illness with loss of appetite, fatigue, vomiting, diarrhea, muscle and joint aches, and jaundice (your skin and the whites of your eyes turn yellow).

Most people recover uneventfully and have no further problem with the virus. Others though may develop a chronic problem with liver damage, liver cancer, and death. The Centers for Disease Control reports that 1.25 million people in the United States have the chronic form of Hepatitis B with 80,000 people developing new cases each year. You are more likely to get Hepatitis B if you engage in high risk behaviors such as having multiple sexual partners or injecting illegal drugs.

About 4,000 people die each year from chronic Hepatitis B infection. You may prevent infection by avoiding risky behaviors and/or by vaccination. We believe that vaccination is the best prevention for everyone and recommend that you have three injections of Hepatitis B vaccine over a six-month period. The vaccine is highly effective and has few side effects … typically some soreness at the injection site.

Most primary and secondary school systems require vaccination for school attendance. The State of Virginia mandates that you either have the vaccinations for college attendance or sign a waiver that you are aware of the risks and prefer not to be vaccinated.

You may receive the vaccine through your private health care provider, health department, or at the UMW Student Health Center.

To register for classes you must have documentation of vaccination or sign the waiver on the other side of this form.

Meningococcal Meningitis

Meningococcal disease is the major cause of bacterial meningitis in children 2-18 years old in the United States. Meningitis is an infection of the brain and spinal cord that can spread throughout the body. The Centers for Disease Control reports approximately 2,600 cases of meningococcal disease each year. If you get meningococcal disease, you have a 10 to 15% chance that you will die from it and another 10% chance that you will lose an arm or a leg, develop kidney failure, brain damage, deafness, seizures, or a stroke.

The risk of meningococcal disease is slightly higher in college freshmen living in dormitories with a risk of 5.4 cases for every 100,000 students. Though the risk is small, the consequences can be severe.

Meningococcal vaccine is 85 to 100% effective in preventing meningococcal disease for serotypes A and C. It does not protect against serotype B, which can cause one third of cases. Thus, the vaccine is effective in preventing many but not all cases of meningococcal disease. Should there be an outbreak of meningitis on the UMW campus, you should contact your health care provider whether you had the vaccine or not. Your risk of getting the disease yourself will be much lower if you have received the vaccine.

You may receive the vaccine through your private health care provider, health department, or at the UMW Student Health Center.

To register for classes you must have documentation of vaccination or sign the waiver on the other side of this form.

Student Name:

Tuberculosis Screening

Based on the guidelines published by the *American College Health Association*, the recommendations from the *Centers for Disease Control* (CDC) and the *American Thoracic Society*, tuberculosis screening is required within six months of college entry primarily by conducting a **Risk Assessment.** For more information, visit www.acha.org or refer to the CDC's *Core Curriculum on Tuberculosis* available at state health departments or at the following website: www.cdc.gov/nchstp/tb/pubs/corecurr/.

If a student is at low risk for tuberculosis, a PPD is not required for entrance into college.

Question 1 **Have you ever had a positive PPD?** ☐ **Yes** ☐ **No**

If NO .....Proceed to Question 2.

If YES .....You must have a chest x-ray and submit the results.

Question 2 **Does the student have SIGNS or SYMPTOMS** of **ACTIVE TB DISEASE**? ☐ **Yes** ☐ **No**

(Fever, night sweats, chills, fatigue, unintended weight loss, loss of appetite, pain with breathing or coughing)

If NO ..... proceed to Question 3.

If YES ..... proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

Question 3 **Is the student a member of a** HIGH RISK GROUP**?** ☐ **Yes** ☐ **No**

Students are in a high risk group if they have HIV … or they inject illegal drugs … or they have resided in, volunteered in or worked in high risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters … or they have diabetes, chronic renal failure, leukemias, lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone >= 15 mg/day for >= one month), or other immunosuppressive disorders.

If NO ..... proceed to Question 4.

If YES ..... place tuberculin skin test (Mantoux only, inject 0.1 ml of purified Protein Derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm. If PPD is not placed, a T-spot, QFT-G or chest x-ray is required.

Question 4

Has the student **LIVED or TRAVELLED** (spent six weeks or more) in countries where TB is endemic? ☐ **Yes** ☐ **No**

Includes those students who have arrived within the past 5 years from countries **OTHER** than those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

If NO to #1, #2, #3 and #4 neither a PPD nor a chest-ray is required. Please sign below.

If YES .....Students should undergo tuberculin skin testing, blood testing and/or chest x-ray.

Please document testing and sign here.

A. **Tuberculin Skin Test** Date given: _____ Date read: _____

Result: _____ mm (record actual millimeters of induration, not redness. If no induration write "0")

Interpretation (based on mm of induration as well as risk factors) ☐ **Positive** ☐ **Negative**

B. **Interferon-Gamma Release Assay** Date: _____ **T-spot** ☐ **Positive** ☐ **Negative** **QFT-G** ☐ **Positive** ☐ **Negative**

C. **Chest X-ray** (required if TB skin test is positive or if PPD has not been placed but patient is at risk of disease)

Results: ☐ **Normal** ☐ **Abnormal** Date of Chest x-ray _____

☐ **INH initiated** Date _____ x _____ months

Your health care provider must sign here to verify tuberculosis screening.

_____ _____ (_____)_____

Signature of Health Care Provider **Date** **Phone Number**