EMORY & HENRY COLLEGE

INTERNAL USE ONLY:
Forward to Dean of Students Office, Wiley 121

Immunization Record and Medical Information Form

Information contained in this six-page form will not affect your admission status and is strictly for the use of E&H College Health Services. Varsity athletes: The athletic training office will receive a copy of pages 1-3. The information will be considered confidential and will not be released to anyone without your knowledge and consent. Information supplied will be used as a point of reference in case of future illness or need for ongoing medical treatment. Please complete pages 1, 2, and 4, answering all personal history and TB screening questions before your appointment with your healthcare provider for the physical evaluation, page 3. Return of this completed form entitles you to be seen at no charge during E&H Health Center doctor/nurse practitioner hours for students. Please complete the entire form paying careful attention to required physician, student, and parent signatures. Questions: 276-944-6219

NOTICE OF PRIVACY PRACTICES – Please read and sign this statement

Emory & Henry College Student Health Center complies with HIPAA (Privacy Practices) regulations. A full list of these regulations may be found on our website, posted at the Student Health Center, or available in print upon request. Federal law requires that we inform you of this privacy statement.

Student Signature _____ Printed Student Name _____ Date Signed _____

Patient Information

LAST NAME (PRINT) _____ FIRST NAME _____ MIDDLE _____ CELL PHONE # _____

HOME ADDRESS (NUMBER & STREET) _____ CITY/TOWN _____ STATE _____ ZIP CODE _____ HOME PHONE # _____

Date of Birth _____ Place of Birth _____ Age _____ Sex _____ Race _____ Marital Status _____

Mother's name and work no. _____ Father's name and work no. _____

Insurance: _____
Group Number: _____
Policy Number: _____
Address: _____
Telephone: _____
Policy holder name: _____

Admission status:
- ❑ First-year
- ❑ Transfer
- ❑ Readmission
- ❑ Graduate

Date of Entrance:
- ❑ Fall
- ❑ Spring
- ❑ Summer

20___

ATTACH A COPY OF FRONT AND BACK OF INSURANCE CARD.

Family History

	AGE	STATE OF HEALTH	DEATH AGE AT	CAUSE OF DEATH	HAVE ANY OF YOUR RELATIVES EVER HAD THE FOLLOWING:	YES	NO	RELATIONSHIP
Father					Asthma, Hay Fever			
Mother					Arthritis			
Brother(s)					Diabetes			
					Epilepsy, Convulsions			
					Heart Disease			
Sister(s)					Kidney Disease			
					Stomach Disease			
					Tuberculosis			

Personal History

If you have ever had any of the following conditions or symptoms, please place a check mark in the appropriate box.

	ADHD/ADD		Female Only		Pain/Pressure in Chest
	Acne/Skin Problems		Irregular Period		Palpitations (Heart)
	Allergy (if so, list)		Severe Cramps		Pneumonia
	Medications		Excessive Flow		Recent Gain or Loss of Weight
	Seasonal		Frequent Anxiety		Recurrent Colds
	Foods (types)		Frequent Depression		Recurrent Headaches
	Anemia/Blood Disorder		Frequent Headaches		Rheumatic Fever or Heart Murmur
	Appendectomy		Gallbladder Trouble or Gallstones		Scarlet Fever
	Arthritis		Gum or Tooth Trouble		Seizures
	Asthma		GYN Surgery		Sexually Transmitted Disease
	Back Problems		Head Injury with Unconsciousness		Shortness of Breath
	Cardiac Problems		Hernia Repair		Sinusitis
	Chicken Pox Yr _____		Hepatitis/Jaundice		Stomach or Intestinal Trouble
	Chronic Cough		High or Low Blood Pressure		Surgery
	Dental Appliances		Insomnia		Thyroid Problems
	Diabetes		Kidney Stones		Tonsillectomy
	Disease or Injury of Joints/Bone		Malaria		Tuberculosis
	Dizziness, Fainting		Measles		Tumor, Cancer, Cyst
	Drug/Alcohol Problem		Migraine Headaches		Urinary Infections/Problems
	Ear, Nose, Throat Trouble		Mononucleosis (Mono)		Worry or Nervousness
	Eating Disorders		Mumps		Other
	Eye Trouble/Glasses/Contacts		Neurological Disorder		

Explain Conditions Checked: _____

Has your physical activity been restricted during the past five years? (Give reasons and durations.) ❑ yes ❑ no

Do you take any medication? If yes, give name and dosage on attached sheet. ❑ yes ❑ no

Have you had any illnesses or injuries requiring hospitalization? (Give details.) ❑ yes ❑ no

Have you received any treatment or counseling for a nervous condition, personality or character disorder, or emotional problems? (Give diagnosis and dates of treatment.) ❑ yes ❑ no

Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years (other than routine checkups)? ❑ yes ❑ no

Are you on medication for cramps or the regulation of periods? (If so, name) ❑ yes ❑ no

Have you been rejected or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons.) ❑ yes ❑ no

_____

Student's Signature Date

_____

Physician's Signature (Acknowledging Review) Date

Physical Evaluation

To the Examining Physician: Please review the student's history and complete the physician's form. Please comment on all positive answers. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect his/her status. It will be used only as a background for providing health care, if this is necessary.

_____ Sex: ❑ Male ❑ Female
LAST NAME FIRST NAME MIDDLE

Height:_____ feet _____ inches Weight:_____ lbs. Overweight _____ Underweight _____

Corrected Vision: Right-20/_____ Left-20/_____ Hearing: R _____ L _____

Pupils: Equal _____ Unequal _____

Pulse: _____ Resp: _____ Temperature:_____ Blood Pressure: _____

Urinalysis: glucose: _____ protein:_____ micro: _____ Hemoglobin (gm/dL) or Hematocrit (%): _____

ARE THERE ABNORMALITIES OF THE FOLLOWING SYSTEMS? DESCRIBE FULLY. USE ADDITIONAL SHEET IF NEEDED.				
❑ yes	❑ no	Head, Ears, Nose, or Throat		
❑ yes	❑ no	Respiratory		
❑ yes	❑ no	Cardiovascular		
❑ yes	❑ no	Gastrointestinal		
❑ yes	❑ no	Hernia		
❑ yes	❑ no	Eyes		
❑ yes	❑ no	Genitourinary	Male:	Female:
❑ yes	❑ no	Musculoskeletal		
❑ yes	❑ no	Metabolic/Endocrine		
❑ yes	❑ no	Neuropsychiatric		
❑ yes	❑ no	Skin		
❑ yes	❑ no	Other:		

General Appearance / General Comments_____

Prescription medication taken regularly: _____

Over-the-counter medication taken regularly:_____

Recommendations for physical activity (PE, intramurals) and participation in varsity sports. ❑ Unlimited ❑ Limited

Do you have any recommendations regarding the care of this student? ❑ yes ❑ no

Is the patient now under treatment for any medical or emotional condition? ❑ yes ❑ no

Varsity Athlete Sport: _____

Per NCAA rules, all athletes must show proof of Sickle Cell Trait Testing (from newborn panel or from current lab blood draw)

Documentation is required. Copy must be attached.

Sickle Cell Positive? ❑ yes ❑ no Sickle Cell Trait? ❑ yes ❑ no

Tuberculin (TB) Screening Questionnaire is required. Please complete pages 4 and 5 (including signature).

_____
Physician's Signature Print Last Name Date

_____
Address Office Phone

Name: _____ Date _____

Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? ❑ Yes ❑ No

(If yes, please CIRCLE the country, below)

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above) ❑ Yes ❑ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above questions, Emory & Henry College requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing or further action is required.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) Yes _____ No _____
History of BCG vaccination? (If yes, consider IGRA if possible.) Yes _____ No _____

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1. TB Symptom Check
Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____
If No, proceed to 2 or 3
If yes, check below:

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive____ negative____

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive____ negative____

**Interpretation guidelines

>5 mm is positive:
- ❑ Recent close contacts of an individual with infectious TB
- ❑ Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- ❑ Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- ❑ HIV-infected persons

>10 mm is positive:
- ❑ Recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- ❑ Injection drug users
- ❑ Mycobacteriology laboratory personnel
- ❑ Residents, employees , or volunteers in high-risk congregate settings
- ❑ Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:
- ❑ Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

Health Care Professional Signature Date

Immunization Record

Name Date of Birth Social Security # / /

Please complete all blanks or attach complete immunization record. A second MMR (measles, mumps, and rubella) immunization is required or proof of immunization by titer. If you have had the disease(s), please note below.
****Required by law.***

* MMR	DATE OF FIRST INJECTION	DATE OF SECOND INJECTION
* Polio Please write date of last dose.	DATE	
Influenza (Annual Immunization Recommended)	DATE OF LAST DOSE	
* Tetanus – Diphtheria This dose has to be within the past ten years.	DATE	Td _____ or Tdap _____
Hepatitis B (Required for Athletic Trainers)	#1 #2 #3 DATES	
Meningococcal Meningitis Vaccine (Strongly Recommended)		
Varicella Virus Vaccine		
HPV (Gardasil) Vaccine	#1 #2 #3 DATES	
Others		

Please mail the completed **six-page** form to:

Admissions Office
Emory & Henry College
PO Box 947 • Emory, Virginia 24327-0010
Telephone: 276-944-6133

You must have this form completed *no later than* August 1 (Fall admission) or January 1 (Spring admission).

A parent or guardian of a student under 18 years of age must sign the following statement to allow the college to authorize emergency treatment. The staff of Emory & Henry College has my permission to authorize emergency medical treatment for our son/daughter, _____.

Parent Signature Date

PARENTAL NOTIFICATION YES ____ NO ____

I permit Emory & Henry College medical staff and its consultants to notify my parents or guardian in the event of an emergency or serious illness.

Student Signature Date