EMORY & HENRY COLLEGE

INTERNAL USE ONLY:
Forward to
Health Center

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 and members of certain affinity groups: The athletic training office will receive a copy of this form. 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 _____ Gender _____ Race _____ Marital Status _____

Parent/Guardian 1 and work # _____ Parent/Guardian 2 and work # _____

Insurance: _____

Group Number: _____

Policy Number: _____

Address: _____

Telephone: _____

Policy holder name: _____ Date of Birth: _____

Admission status:

- ☐ First-year
- ☐ Transfer
- ☐ Readmission

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	☐	Neurological Disorder
☐	Acne/Skin Problems	☐	Irregular Period	☐	Pain/Pressure in Chest
☐	Allergy (if so, list)	☐	Severe Cramps	☐	Palpitations (Heart)
☐	Medications	☐	Excessive Flow	☐	Pneumonia
☐	Seasonal	☐	Eye Trouble/Glasses/Contacts	☐	Recent Gain or Loss of Weight
☐	Foods (types)	☐	Frequent Anxiety	☐	Recurrent Colds
☐	Anemia/Blood Disorder	☐	Frequent Depression	☐	Recurrent Headaches
☐	Appendectomy	☐	Frequent Headaches	☐	Rheumatic Fever or Heart Murmur
☐	Arthritis	☐	Gallbladder Trouble or Gallstones	☐	Scarlet Fever
☐	Asthma	☐	Gum or Tooth Trouble	☐	Seizures
☐	Back Problems	☐	GYN Surgery	☐	Sexually Transmitted Disease
☐	Cardiac Problems	☐	Head Injury with Unconsciousness	☐	Shortness of Breath
☐	Chicken Pox Yr _____	☐	Hernia Repair	☐	Sinusitis
☐	Chronic Cough	☐	Hepatitis/Jaundice	☐	Stomach or Intestinal Trouble
☐	Concussion(s)	☐	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

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/NP/PA Signature (Acknowledging Review) _____ Date _____

Physical Evaluation

To the Examining Provider: Please review the student's history (page 2) and complete this physical form. Please comment on all positive answers. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect their status and will only be used as background for providing healthcare.

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

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, hemoglobin solubility test, or current lab blood draw sickle cell trait screening test.

Documentation is required. Copy must be attached.

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

Physician/NP/PA 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
- ○ Anguilla
- ○ Argentina
- ○ Armenia
- ○ Azerbaijan
- ○ Bangladesh
- ○ Belarus
- ○ Belize
- ○ Benin
- ○ Bhutan
- ○ Bolivia (Plurinational State of)
- ○ Bosnia and Herzegovina
- ○ Botswana
- ○ Brazil
- ○ Brunei Darussalam
- ○ Bulgaria
- ○ Burkina Faso
- ○ Burundi
- ○ Cotê d'Ivoire
- ○ Cabo Verde
- ○ Cambodia
- ○ Cameroon
- ○ Central African Republic
- ○ Chad
- ○ China
- ○ China, Hong Kong SAR
- ○ China, Macao SAR
- ○ Colombia
- ○ Comoros
- ○ Congo
- ○ Democratic People's Republic of Korea
- ○ Democratic Republic of the Congo
- ○ Djibouti
- ○ Dominican Republic
- ○ Ecuador
- ○ El Salvador
- ○ Equatorial Guinea
- ○ Eritrea
- ○ Eswatini
- ○ Ethiopia
- ○ Fiji
- ○ French Polynesia
- ○ Gabon
- ○ Gambia
- ○ Georgia
- ○ Ghana
- ○ Greenland
- ○ Guam
- ○ Guatemala
- ○ Guinea
- ○ Guinea-Bissau
- ○ Guyana
- ○ Haiti
- ○ Honduras
- ○ India
- ○ Indonesia
- ○ Iraq
- ○ Kazakhstan
- ○ Kenya
- ○ Kiribati
- ○ Kuwait
- ○ Kyrgyzstan
- ○ Lao People's Democratic Republic
- ○ Latvia
- ○ Lesotho
- ○ Liberia
- ○ Libya
- ○ Lithuania
- ○ Madagascar
- ○ Malawi
- ○ Malaysia
- ○ Maldives
- ○ Mali
- ○ Marshall Islands
- ○ Mauritania
- ○ Mexico
- ○ Micronesia (Federated States of)
- ○ Mongolia
- ○ Morocco
- ○ Mozambique
- ○ Myanmar
- ○ Namibia
- ○ Nauru
- ○ Nepal
- ○ Nicaragua
- ○ Niger
- ○ Nigeria
- ○ Niue
- ○ Northern Mariana Islands
- ○ Pakistan
- ○ Palau
- ○ Panama
- ○ Papua New Guinea
- ○ Paraguay
- ○ Peru
- ○ Philippines
- ○ Portugal
- ○ Qatar
- ○ Republic of Korea
- ○ Republic of Moldova
- ○ Romania
- ○ Russian Federation
- ○ Rwanda
- ○ Sao Tome and Principe
- ○ Senegal
- ○ Sierra Leone
- ○ Singapore
- ○ Solomon Islands
- ○ Somalia
- ○ South Africa
- ○ South Sudan
- ○ Sri Lanka
- ○ Sudan
- ○ Suriname
- ○ Tajikistan
- ○ Thailand
- ○ Timor-Leste
- ○ Togo
- ○ Tokelau
- ○ Trinidad and Tobago
- ○ Tunisia
- ○ 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 2018. Countries and territories with incidence rates of ≥20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

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 _____

---

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____

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) ***If indicated, or Interferon Gamma Release Assay (IGRA)***

(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:

- ❑ Foreign born or travelers to the U.S. 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.

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with apppropriate medication.

Health Care Professional Signature Date

Immunization Record

Name Date of Birth Social Security # / /

Please complete all blanks or attach complete immunization record. *Immunizations required by law of proof of immunity by titer (attach). If you have had the disease(s), please note below.

* 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 A	#1 #2 DATES	
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
P.O. Box 947 • Emory, Virginia 24327-0947
Telephone: 276-944-6133

Or, fax directly:
Emory & Henry College
Health Center
Fax: 276-944-6666

You must have this form completed *no later than* July 1 (Fall admission) or December 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

EMERGENCY NOTIFICATION YES ___ NO ___

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

_____
Student Signature Date