AD 3 (Rev. 1/2015)

Health Record Form

RADFORD UNIVERSITY

www.radford.edu

COMMONWEALTH OF VIRGINIA LAW AND/OR RADFORD UNIVERSITY REQUIRES THAT THE HEALTH RECORD FORM AND CERTIFICATE OF IMMUNIZATION BE COMPLETED AND SUBMITTED TO THE STUDENT HEALTH CENTER PRIOR TO ENROLLMENT AT RADFORD UNIVERSITY.

Send directly to: Student Health Center, Radford University, P.O. Box 6899, Radford, VA 24142

This completed form must be returned by June 1 for fall semester and December 1 for spring semester.

Personal Information

Name ______________________________ Student ID# ____________
Last First Middle (Student ID # is Required to Process this form.)

Date of Birth ____ / ____ / ____ Sex ______ Marital Status ____________
Mo Day Year

College Address ______________________________ Cell Phone (____) ____________
No. & Street City State Zip

Permanent Home Address ______________________________ Telephone (____) ____________

Parent/Guardian Email Address ______________________________

In Case of Emergency, Notify ____________ (____) ____________ ____________
Name Telephone Relationship

Family Physician ____________ ____________
Name Address

Medical Insurance Company ____________ Policy No. ____________
Name

Type of plan: ☐ HMO ☐ PPO ☐ Indemnity ☐ Other ☐ Uninsured

Date of Entrance to University ______________________________

Are you a graduate of RU? ☐ Yes ☐ No

If Yes, Date Of Entrance: ____________

...and Graduation Date: ____________

Medical History (Confidential)

1. Name any chronic illness or major medical condition for which you are being treated. Please also list any hospitalizations / surgeries.

____

____

2. List medications you are currently taking ______________________________

____

3. List any medicine, food, or environmental substance to which you are ALLERGIC and describe allergic reaction.

____

____

Over 18: I, hereby, give the Student Health Center permission to treat me whenever I present myself to the Center.

______________________________ ____________
Student's Signature Date

Under 18: Statement must be signed if student is under 18 years of age. I/we, the parents of ____________ hereby authorize and give permission to the Student Health Center to treat my/our child whenever my/our child presents to the Health Center.

______________________________ ____________
Signature of Parent/Guardian Date

(Form continues through next two pages)

IMPORTANT REQUIREMENT

Commonwealth of Virginia Law and Radford University require all students to submit a health record with documented immunizations. This MUST be signed by a health care provider.

In case of an incomplete immunization record, preregistration for the following semester will be blocked.

The following immunization record must be completed by a **physician or licensed health professional.** All immunizations must be current.

CERTIFICATE OF IMMUNIZATION*

Do NOT send copies of immunization records – immunizations must be entered on this form and signed by a health care provider.

REQUIRED IMMUNIZATIONS	VACCINE DOSES ADMINISTERED			
HEPATITIS B (For *combined Hep. A + B*, do not use this line. Instead, check here:___ and complete the appropriate line in *"Recommended but Not Required"*) Titer ☐ Pos ☐ Neg ___/___/___ Mo Day Yr	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr	3) ___/___/___ Mo Day Yr	Date series completed ___/___/___ Mo Day Yr
MENINGOCOCCAL VACCINE Must have at least one vaccine after the age of 16	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr		
MEASLES, MUMPS, RUBELLA (MMR) Students born before 1957 are not required to have a second MMR vaccination.	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr	Titers only needed if dates unavailable Measles Titer ☐ Pos ☐ Neg ___/___/___ Mo Day Yr Mumps Titer ☐ Pos ☐ Neg ___/___/___ Mo Day Yr Rubella Titer ☐ Pos ☐ Neg ___/___/___ Mo Day Yr	
TETANUS DIPHTHERIA ADULT PERTUSSIS (TDAP) On or after 2006	___/___/___ Mo Day Yr			
POLIOMYELITIS (OPV or IPV)	Have you completed the series? ☐ yes ☐ no		___/___/___ date completed Mo Day Yr	
VARICELLA (two doses one month apart for adults with no history of disease)	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr	☐ Had Disease Date ___/___/___	Titer ☐ Pos ☐ Neg ___/___/___ Mo Day Yr

RECOMMENDED — PLEASE INCLUDE ADMINISTRATION DATES			
HPV, Quadrivalent or Bivalent (age 26 and under)	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr	3) ___/___/___ Mo Day Yr
HEPATITIS A	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr	
COMBINED HEPATITIS A + B VACCINE Hepatitis B is required. See above.	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr	3) ___/___/___ Mo Day Yr
PNEUMOCOCCAL VACCINE (high-risk persons)	1) ___/___/___ Mo Day Yr		

HEALTH CARE PROVIDER SIGNATURE

***This form will not be accepted if not signed by a health care provider**

Printed Name ______________________ Phone ______________

Address ______________________________________

Signature ______________________ Date ______________

†MEDICAL EXEMPTION

☐ DTP ☐ Td ☐ Hepatitis B ☐ Measles ☐ Rubella ☐ Mumps ☐ Meningococcal Vaccine ☐ OPV

As specified in §23-7.5 of the Code of Virginia, I certify that administration of the vaccine(s) designated above would be detrimental to this student's health.

The vaccine(s) is (are) specifically contraindicated because ______________________

____

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

____

______________________ ______________
Signature of Physician or Health Department Official Date

†Religious Exemption: Any student who objects on the grounds that administration of immunizing agents conflicts with his 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.

Tuberculosis Screening: Required Of All Students

Fill out the first section and take to your health care provider with your immunization record

Name ______________________ Date of Birth: ___/___/_____ (MM DD YYYY) Student ID Number: ____________

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER. TB screening must be completed within six months.
Please answer the following questions.

1. Does the student have signs or symptoms of active TB disease? ☐ YES ☐ NO

If NO, proceed to question 2.

If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, QFT-TB test, chest x-ray and sputum evaluation as indicated. Documentation required that all tests are negative or that treatment is effective and student free of communicable disease.

2. Is the student a member of a high-risk group? ☐ YES ☐ NO

Categories of high-risk students include those: with HIV infection; who inject drugs; who 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; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone > 15 mg/d for > 1 month) or other immunosuppressive disorders.

If NO, continue to question 3.

If YES, obtain QFT (preferred) or perform TST. If positive TST, obtain QFT.

QFT-TB Date obtained: ___/___/_____ **Result:** ☐ Positive ☐ Negative

If positive QFT, see INTERPRETATION below.

OR TST: Date given: ___/___/_____ Date read: ___/___/_____ Result: __________mm (transverse induration

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

If positive, please obtain QFT: Date obtained: ___/___/_____ **Result:** ☐ Positive ☐ Negative

If positive QFT, obtain CXR: Date: ___/___/_____ **Result:** ☐ Normal If abnormal CXR, return to Question 1 - yes

If normal CXR, INH initiated Date: ___/___/_____ Completed: ___/___/_____

3. Was the student BORN in, LIVED or TRAVELED to countries OTHER THAN those on the following list? ☐ YES ☐ NO

Albania, American Samoa, Andorra, Antigua and Barbuda, Aruba, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Curacao, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Monaco, Montenegro, Montserrat, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tokelau, Tonga, Trinidad & Tobago, United Arab Emirates, United Kingdom, United States Virgin Islands, West Bank and Gaza Strip, United States of America

IF NO, Please sign below.*

If YES, obtain QFT: Date obtained: ___/___/_____ **Result:** ☐ Positive ☐ Negative (If negative, sign form below)

If positive QFT, obtain CXR: Date: ___/___/_____ **Result:** ☐ Normal If abnormal CXR, return to Question 1 - yes

If normal CXR, INH initiated Date: ___/___/_____ Completed: ___/___/_____

***HEALTH CARE PROVIDER SIGNATURE**

Signature required as validation of correct information for TB assessment

***This information will not be accepted if not signed by a health care provider**

NOTE: Current CDC Guidelines recommend treatment of positive results. To verify positive TST results, a serology IGRA (QFT) should be obtained. A CXR only confirms active disease and does not rule out latent disease.

Printed Name ______________________ Phone ______________

Address ______________________________________

Signature ______________________ Date ______________