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

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