Dear Student:

Congratulations on your acceptance to Radford University. The staff of the Student Health Services look forward to assisting you with your health care. In order to do this more effectively, we need your health information on or before the due date (see top of next page).

The completion of the medical and immunization information is required by the Commonwealth of Virginia Law (Code of Virginia, Section 23-7.5) and Radford University prior to attending class. If the completed form is not received, the law requires that you be prevented from class registration for the second semester.

The immunization and medical history may be obtained from your health care provider, the health department or most recent school attended. This form does not require a physical but does require the signature of a health care provider. You may fax the form to 540-831-6638 but the original completed form MUST be mailed to:

Radford University Student Health Services
PO Box 6899
Radford, Virginia 24142

Please refer to our Radford University Student Health website or contact our office at 540-831-5111 if you have any questions.

Sincerely,
Abby Mundy
Director, Student Health Services

**CHECKLIST:**

- **Completed health record** prior to attending class. Must have ALL required immunizations and provider signature provider signature after immunization information and after TB risk assessment.

- **Medical records** (If you have chronic/serious medical problems, you should provide a summary from your health care provider to the student health center. This may be attached to this form.)

**IMPORTANT ITEMS TO REMEMBER TO BRING WITH YOU TO RADFORD:**

- **Health Insurance Card** (Be advised to carry you health insurance card with you at all times. You also need to know what coverage you have and how to contact the health insurance company if needed.)

- **Prescriptions** (You should have a record of your prescriptions including doses and reasons for medication.)

- **First aid supplies** (Digital thermometer, cold pack, first aid kit with band-aids, antibiotic ointment, ibuprofen, tylenol, etc.)

- **List of allergies to medications and foods** (This also needs to be included on the required health record form.)
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#  ________________________________________________

Date of Birth ____________/____________/________________ Sex _____________ Marital Status __________________________

College Address _________________________________________________________________________________________ Cell Phone (_____ ) ________________________________

Permanent Home Address __________________________________________________________________________ Telephone (_____ ) ________________________________

Parent/Guardian Email Address __________________________________________________________________________

In Case of Emergency, Notify ___________________________________________ (______) ________________________________  _________________________________________

Family Physician ___________________________________  ________________________________________________________________________________________________

Medical Insurance Company __________________________________________________ Policy No. ___________________________________________________________________

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

Date of Entrance to University ________________________________________

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.

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

Are you a graduate of RU?  ☐ Yes  ☐ No

If Yes, Date Of Entrance:__________________________

…and Graduation Date: ______________________

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 ______________________

Radford University Student Health is a full functioning primary care physician's office. If you wish to make us your primary care while at Radford University, please sign below.

Signature ___________________________ 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.

<table>
<thead>
<tr>
<th>REQUIRED IMMUNIZATIONS</th>
<th>VACCINE DOSES ADMINISTERED</th>
<th>Date series completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEPATITIS B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(<em>For combined Hep. A + B, do not use this line. Instead, check here: Hepatitis B is required. See above.</em>)</td>
<td>1) ____ / ____ / ____ Mo Day Yr</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) ____ / ____ / ____ Mo Day Yr</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3) ____ / ____ / ____ Mo Day Yr</td>
</tr>
<tr>
<td>Titer □ Pos □ Neg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| MENINGOCOCCAL VACCINE (ACY, W) | 1) ____ / ____ / ____ Mo Day Yr | Titer only needed if dates unavailable |
|                                | 2) ____ / ____ / ____ Mo Day Yr | |

| MEASLES, MUMPS, RUBELLA (MMR) | 1) ____ / ____ / ____ Mo Day Yr | Measles Titer □ Pos □ Neg |
| Students born before 1957 are not required to have a second MMR vaccination. |
| 2) ____ / ____ / ____ Mo Day Yr | Mumps Titer □ Pos □ Neg |
| |
| |
| TETANUS DIPHTHERIA ADULT PERTUSSIS (TDAP) | 1) ____ / ____ / ____ Mo Day Yr | Rubella Titer □ Pos □ Neg |
| Within the last 10 years |
| 2) ____ / ____ / ____ Mo Day Yr | |
| |
| POLIOMYELITIS (OPV or IPV) | Have you completed the series? □ yes □ no |
| 1) ____ / ____ / ____ Mo Day Yr | date completed: ____ / ____ / ____ Mo Day Yr |
| 2) ____ / ____ / ____ Mo Day Yr | |

| VARICELLA | 1) ____ / ____ / ____ Mo Day Yr |
| (two doses for individuals with no history of disease) |
| 2) ____ / ____ / ____ Mo Day Yr |
| □ Had Disease |
| Date ____ / ____ / ____ Mo Day Yr |
| Titer □ Pos □ Neg |

<table>
<thead>
<tr>
<th>RECOMMENDED – PLEASE INCLUDE ADMINISTRATION DATES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SEROGROUP B MENINGOCOCCAL VACCINE</td>
<td>1) ____ / ____ / ____ Mo Day Yr</td>
</tr>
<tr>
<td>On or after 2016</td>
<td>2) ____ / ____ / ____ Mo Day Yr</td>
</tr>
<tr>
<td>2 Dose Series</td>
<td>3) ____ / ____ / ____ Mo Day Yr</td>
</tr>
<tr>
<td>3 Dose Series</td>
<td></td>
</tr>
</tbody>
</table>

| 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 |
|                                                 | 3) ____ / ____ / ____ Mo Day Yr |

| COMBINED HEPATITIS A + B VACCINE                | 1) ____ / ____ / ____ Mo Day Yr |
| Hepatitis B is required. See above.             | 2) ____ / ____ / ____ Mo Day Yr |
|                                                 | 3) ____ / ____ / ____ Mo Day Yr |

| PNEUMOCOCCAL VACCINE (high-risk persons)        | 1) ____ / ____ / ____ Mo Day Yr |

**HEALTH CARE PROVIDER SIGNATURE**

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 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.

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

**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.

Signature of Physician or Health Department Official __________________________ Date ____________
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: __/__/____  Student ID Number: __________________

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER. TB screening must be completed within six months.
Please answer ALL 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, Perform TST or obtain QFT (preferred). If positive TST, obtain QFT.

   **TST:**
   - Date given: ___/___/_____
   - Date read: ___/___/_____
   - Result: _________mm (transverse induration)

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

   If positive QFT, see INTERPRETATION below.

   **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: ___/___/_____

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, 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, No TST Required. 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: ___/___/_____

**HEALTH CARE PROVIDER SIGNATURE**

Signature required as validation of correct information for TB assessment

*HEALTH CARE PROVIDER SIGNATURE*  __________________________  Date: __/__/_____

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: __/__/_____

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