

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.)

HEALTH RECORD FORM

AD 3 (Rev. 10/2016)

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 _____

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.

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 <input type="checkbox"/> Pos <input type="checkbox"/> Neg ___/___/___ Mo Day Yr	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr	3) ___/___/___ Mo Day Yr	Date series completed ___/___/___ Mo Day Yr
MENINGOCOCCAL VACCINE (ACY, W) 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	Titrers only needed if dates unavailable Measles Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg ___/___/___ Mo Day Yr Mumps Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg ___/___/___ Mo Day Yr Rubella Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg ___/___/___ Mo Day Yr	
TETANUS DIPHTHERIA ADULT PERTUSSIS (TDAP) Within the last 10 years	___/___/___ Mo Day Yr			
POLIOMYELITIS (OPV or IPV)	Have you completed the series? <input type="checkbox"/> yes <input type="checkbox"/> no date completed: ___/___/___ Mo Day Yr			
VARICELLA (two doses for individuals with no history of disease)	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr	<input type="checkbox"/> Had Disease Date ___/___/___	Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg ___/___/___ Mo Day Yr

RECOMMENDED – PLEASE INCLUDE ADMINISTRATION DATES

SEROGROUP B MENINGOCOCCAL VACCINE <input type="checkbox"/> 2 Dose Series On or after 2016 <input type="checkbox"/> 3 Dose Series	1) ___/___/___ Mo Day Yr	2) ___/___/___ Mo Day Yr	3) ___/___/___ Mo Day Yr
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		

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

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 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: ____/____/____ Student ID Number: _____
MM DD YYYY

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: ____/____/____ 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, 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: ____/____/____ Completed: ____/____/____

Signature required as validation of correct information for TB assessment

***HEALTH CARE PROVIDER SIGNATURE**

***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 _____