Required Health Records for all Students

Failure to complete all required forms and immunizations can prohibit you from registering for classes.

Health Records are due SEPTEMBER 1 for Fall Students and FEBRUARY 1 for Spring Students.
HEALTH FORMS – CHECKOFF SHEET

Below is a checklist to help you in organizing your required Health Record documentation.

All students are required to submit the following documentation:

- **Report of Medical History Form** (completed by student)

- **Physical Exam Form** (MUST BE on form AND signed by Physician, Physician Assistant, or Nurse Practitioner). Must be current – within 12 months of beginning class.

- **Immunization Record Form** (MUST BE on form AND signed by Physician, Physician Assistant, or Nurse Practitioner)
  - **Tdap or tetanus booster** – within the last 10 years
  - **MMR** (measles, mumps, rubella) – 2 dose series or titer showing immunity
  - **Tuberculosis** – Quantiferon Gold blood test, T-Spot blood test, or PPD test are required annually (must include date given, date read, and results).
  - **Polio** – verified case, record of childhood vaccination (strongly preferred), titer, or physician’s note stating the following: “Patient is not a candidate for a booster at this time.”
  - **Hep B** – 3 dose series or titer showing immunity
  - **Chicken Pox** – verified case, 2 dose series, or titer showing immunity (required for PA students; must also have documentation)
  - **Meningitis** – **Required for all Students**
  - **Influenza** – **Required for all Clinical Students**; Recommended for all students each season (October – March)

- **Continued Responsibility Statement** (signed by student)

- **Emergency Contact** (completed by student)

- **Health Insurance** (submit copy of front and back of ID card)
  - Recommended for all students
  - **Required** for ALL students entering a CLINICAL semester.

- **Medical Consent Form for Minors** (signed by student if under 18 years of age)

**STUDENTS ARE ENCOURAGED TO MAINTAIN COPIES OF ALL DOCUMENTS SUBMITTED AS IMMUNIZATION RECORDS MAY BE REQUIRED FOR EMPLOYMENT AFTER GRADUATION.**
REPORT OF PERSONAL MEDICAL HISTORY

(check if you have had any of the following)

- Anemia
- Arthritis
- Asthma
- Alcohol Abuse
- Back Problem
- Cancer
- Chronic Fatigue
- Convulsion
- Diabetes
- Emphysema
- Epilepsy
- Fainting Spells
- Muscle Disorder
- Frequent Cough
- Glasses/Contact Lens
- Head Injury/Concussion
- Hearing Aid(s)
- Heart Problem/Murmur
- Hepatitis
- High Blood Pressure
- Infectious Mononucleosis
- Kidney Problems
- Lyme Disease
- Malaria
- Meningitis
- Migraine/Frequent Severe Headaches
- Night Sweating
- Recent Weight Gain or Loss/how many _____ lbs.
- Rheumatic Fever
- Sinusitis
- Tonsillitis (Chronic)
- Tuberculosis
- Unexplained Aches & Pains
- Use Smokeless/Chewing tobacco
- Smoke Cigarettes, Cigars, or Pipe
- How many years ______
- How many a day ______

Other medical or psychological conditions that you believe we should be aware of?  (Please explain)
____________________________________________________________________________________
____________________________________________________________________________________
List an allergies _________________________________________________________________
____________________________________________________________________________________
Have you ever been hospitalized? Had any operations? (Please note details) ________________________
____________________________________________________________________________________
____________________________________________________________________________________
List all current medications _______________________________________________________________
List any serious injury _________________________________________________________________

FAMILY HISTORY

<table>
<thead>
<tr>
<th>AGE</th>
<th>STATE OF HEALTH</th>
<th>OCCUPATION</th>
<th>AGE OF DEATH</th>
<th>CAUSE OF DEATH</th>
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Father
Mother
Brother(s)
Sister(s)

Has any of your immediate family ever had any of the following? (Please state relationship)
- Cancer ________________________________
- Diabetes ______________________________
- Heart Disease __________________________
- High Blood Pressure _____________________
- Kidney Problems _________________________
- Tuberculosis ____________________________
- Other _________________________________

I hereby certify that the information submitted on this record is complete and correct.

Student Name – Printed LEGIBLY          Date

Student Signature          Date
# PHYSICAL EXAMINATION FORM

A physical examination is required and must be completed and signed by appropriate personnel. It must be current – within 12 months of starting classes.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth (month/day/year)</th>
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Permanent Address | City | State | Zip Code | Area Code/Phone Number | BP |
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Height ________ Weight ________

**IF REQUIRED:**

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<thead>
<tr>
<th>Semester of Entry</th>
<th>Fall</th>
<th>Spring</th>
<th>Summer</th>
<th>Yr.</th>
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Program of Study:

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Vision:

Corrected Right 20/____ Left 20/____

Uncorrected Right 20/____ Left 20/____

Program of Study:

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Hearing:

(gross) Right _____ Left _____

15 ft. Right _____ Left _____

Are there abnormalities? Normal Abnormal DESCRIPTION (attach additional sheets if necessary)

<table>
<thead>
<tr>
<th>1. Head, Ears, Nose, Throat</th>
<th>Normal</th>
<th>Abnormal</th>
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<thead>
<tr>
<th>2. Eyes</th>
<th>Normal</th>
<th>Abnormal</th>
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<thead>
<tr>
<th>3. Respiratory</th>
<th>Normal</th>
<th>Abnormal</th>
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<thead>
<tr>
<th>4. Cardiovascular</th>
<th>Normal</th>
<th>Abnormal</th>
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<thead>
<tr>
<th>5. Gastrointestinal</th>
<th>Normal</th>
<th>Abnormal</th>
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<tr>
<th>6. Hernia</th>
<th>Normal</th>
<th>Abnormal</th>
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<tr>
<th>7. Genitourinary</th>
<th>Normal</th>
<th>Abnormal</th>
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<tr>
<th>8. Musculoskeletal</th>
<th>Normal</th>
<th>Abnormal</th>
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<tr>
<th>9. Metabolic/Endocrine</th>
<th>Normal</th>
<th>Abnormal</th>
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<tr>
<th>10. Neuropsychiatric</th>
<th>Normal</th>
<th>Abnormal</th>
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<tr>
<th>11. Skin</th>
<th>Normal</th>
<th>Abnormal</th>
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<tr>
<th>12. Mammary</th>
<th>Normal</th>
<th>Abnormal</th>
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A. Is there loss or seriously impaired function of any paired organs? Yes ___ No___

Explain

B. Is student under treatment for any medical or emotional condition? Yes ___ No___

Explain

C. Recommendation for physical activity (clinical experiences, intramurals, etc.) Unlimited ___ Limited ___

Explain

D. Is student physically and emotionally healthy? Yes ___ No___

Explain

E. Other medical or psychological conditions that you believe we should be aware of?

Based on my assessment of this student’s physical and emotional health on _______________, he/she appears able to participate in the activities of a health profession in a clinical setting. (Date) Yes ____ No ____

If no, please explain

Signature of Healthcare Professional (MD, PA, NP, Nurse, etc.)

Day

Print name of Healthcare Professional (MD, PA, NP, Nurse, etc.)

Area Code/Phone Number

Office Address | City | State | Zip Code |  
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STUDENT IMMUNIZATION RECORD

This form is mandatory and must be signed by a Healthcare Professional (MD, PA, NP, Nurse, etc.)

Name: _______________________________________________________________________

Last          First                                      Middle

### Tetanus/Diphtheria/Pertussis – Tdap required every 10 years
Tdap date _____________

### Measles, Mumps, Rubella (MMR)  Required for all students

Dose 1 ___________ or Titer Date _____________ (Attach Titer Copy)

Dose 2 ___________

### Tuberculosis – Required annually for all students (IF PPD, 2-step required if no PPD in last 15 months)

**Tuberculin Skin Test**

1-step: Date Given: _______ Date Read _______ Negative □ Positive □
(attach documentation for previous PPD results)

2-step: 1st Date Given: _______ Date Read _______ Negative □ Positive □
2nd Date Given: _______ Date Read _______ Negative □ Positive □

OR

**QuantiFERON TB Gold Test**

Date Given: _______ Negative □ Positive □

If PPD is positive, attach Chest X-Ray Report  (Chest X-rays are good for 5 years.)

### Polio  Required for all students

Dose 1 ___________ Dose 2 ___________ or Titer Date _____________ (Attach titer copy showing immunity)

Dose 3 ___________ Dose 4 ___________

### Hepatitis B

Dose 1 ___________ or Titer Date _____________ (Attach titer copy showing immunity)

Dose 2 ___________

Dose 3 ___________ Required for all students

### Varicella (Chicken Pox)  Required for all students; PA students require a Titer

Dose 1 ________ Verified

Case Date ___________ or Titer Date _____________ (Attach titer copy showing immunity)

Dose 2 ___________

### Bacterial Meningitis – Required for resident students; recommended for all students

Date ___________ Exp Date ___________

### Influenza Vaccination – Required for all clinical students; Recommended for all students each season

Date ___________ (attach documentation)

### Healthcare Professional Name, Address, Phone Number and Signature (Required)

Name ___________________________________________ Date ___________________________

Signature ___________________________________________ Phone ___________________________

Address ___________________________________________
<table>
<thead>
<tr>
<th>Immunization Requirements</th>
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<tbody>
<tr>
<td><strong>Tetanus-Diptheria</strong></td>
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</table>
| **Measles, Mumps, Rubella (MMR) 2 doses required** | Dose 1 – given at age 12-15 months or later  
Dose 2 – given at age 4-6 years or later, and at least one month after first dose. |
| **Tuberculosis must be completed annually** | Quantiferon gold or T-spot blood test or PPD: Completed every 12 months – screening does not count – must have negative blood or scratch test.  
If scratch test s done (PPD) a 2-step PPD is REQUIRED if you have not had a PPD in the last 5 months.  
If you have had a PPD in the last 15 months, results from past PPDs must be submitted as well as the most recent PPD.  
If a student shows signs or symptoms of active tuberculosis disease you must proceed with additional evaluation to exclude active tuberculosis disease including tuberculin testing, chest X ray, and sputum evaluation.  
**Negative chest x-rays are valid for 5 years.** |
| **Polio – OPV alone Oral Sabin – 3 doses**  
**IPV/OPV sequential – 4 doses**  
**IPV alone injected Salk – 4 doses** | Primary series in childhood meets requirements; three primary series schedules are acceptable. |
| **Hepatitis B** | Three doses of vaccine or two doses of adult vaccine in adolescents 11 – 15 years of age or a positive Hepatitis antibody meets the requirement. |
| **Varicella** | Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after the age of 13 or older meets the requirement.  
History of Chicken Pox - A letter from the student’s parent listing history of chicken pox, dated and signed will meet the requirement. |
| **Bacterial Meningitis – 1 dose** | **Required for all students** |
| **Influenza – Each season** | **Required for all clinical students;**  
Recommended for all students each season (October – March). |
CONTINUED RESPONSIBILITY STATEMENT

1) I understand that it is my responsibility to keep immunizations and TB skin tests current.

2) I agree to inform clinical instructors or the department head of any illness or health problem that could possibly affect my performance or the welfare of my patients in the clinical area.

3) I understand that if I am in a clinical rotation I am to have current health and accident insurance during each academic semester. I will maintain this coverage throughout the entire year.

4) I understand that I am to have a current CPR card in a clinical semester.

5) I attest that I have never been disbarred from and am not currently under investigation by a health (nursing/medicine, etc.) state licensure board.

6) I understand that I need to inform the College if I become aware that I am under investigation or if I am convicted of a criminal charge.

7) I understand that disclosure of the above is necessary to protect my health and the well-being of patients for whom I may provide care.

I have read the above and agree to act accordingly.

_________________________________ ___________________________
Student’s Printed (legible) Name   Date

_________________________________
Student’s Signature
EMERGENCY CONTACT INFORMATION
PLEASE PRINT CLEARLY

Student’s Printed Name __________________________________________________

Address: ________________________________________________________________
   Street #   City   State   Zip

Phone: _________________________  Cell Phone: ______________________

Program of Study: ___________________       Advisor: _________________________

Physician’s Name/Phone Number: __________________________________________
   (Name)   (Phone Number)

Emergency Contact #1

Name: _________________________   Relationship to Student __________________

Address: ________________________________________________________________
   Street #   City   State   Zip

Phone #1: _________________________   Phone #2 _________________________

Please circle one: Home  Work  Cell  Please circle one: Home  Work  Cell

Emergency Contact #2

Name: _________________________   Relationship to Student __________________

Address: ________________________________________________________________
   Street #   City   State   Zip

Phone #1: _________________________   Phone #2 _________________________

Please circle one: Home  Work  Cell  Please circle one: Home  Work  Cell
HEALTH INSURANCE INFORMATION

All students are encouraged to have health insurance coverage.

Students in clinical semesters ARE REQUIRED to have health insurance coverage.

Students in clinical semesters who do not return this form prior to the beginning of their clinical semester WILL NOT be allowed to attend their clinical experience.

Medicaid coverage will be accepted with appropriate benefit card

Military IDs are accepted if you have military insurance

I understand that I am legally responsible for any medical expenses incurred during my enrollment and neither the College nor any clinical site will be responsible for my medical expenses.

Student’s Printed (legible) Name: ____________________________

Social Security Number: ______________

Insurance Company Name: ____________________________________

Policy Number: __________________ Group Number: __________________

Subscriber Name: ____________________________________________

Signature: ______________________________ Date: __________________

Student should sign if over 18 years of age.
Parents should sign if student is under 18 years of age.

ATTACH A COPY OF YOUR CURRENT INSURANCE CARD, FRONT, AND BACK TO THIS FORM.

Please attach a copy of the front of your insurance card here.

Please attach a copy of the back of your insurance card here.
MEDICAL CONSENT FORM FOR MINORS (Under Age 18)

Dear Parent or Legal Guardian:

The purpose of this consent form is to obtain permission from the parent or legal guardian for Radford University to seek treatment for a student who is under the age of 18 and therefore legally a minor.

Radford University has my permission to seek treatment for my child (print name of child legibly) ___________________________________________ in the event of a medical emergency. I understand that the College will make every effort to contact me before seeking this treatment if possible. I realize that Virginia State Law and professional codes of ethics may limit my access to confidential medical information regarding the treatment of my child.

________________________________________________________________________________________

Name of Student

________________________________________________________________________________________

Name of Parent/Guardian (print) ___________________________ Relationship ___________________________

Signature ___________________________ Date ___________________________

________________________________________________________________________________________

Street Address ___________________________ Home Phone (please include area code) ________________

________________________________________________________________________________________

City, State, Zip ___________________________ Work Phone (please include area code) ________________

________________________________________________________________________________________

Cell Phone (please include area code) ___________________________