Health Record Form
RADFORD UNIVERSITY

RU
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

Local Address _____ Telephone (_____)_____
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.

_____

_____

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, including tetanus (within the last 10 years).

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			
Primary Series DIPHTHERIA (DT, Td), TETANUS (DTap), PERTUSSIS (DTP)	Have you completed the series? ☐ yes ☐ no		___/ ___/ ___ date completed Mo Day Yr	
POLIOMYELITIS (OPV or IPV)	Have you completed the series? ☐ yes ☐ no		___/ ___/ ___ date completed Mo Day Yr	
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
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	
MENINGOCOCCAL VACCINE	1) ___/ ___/ ___ Mo Day Yr	2) ___/ ___/ ___ Mo Day Yr		
DIPHTHERIA TETANUS PERTUSSIS (Adult Booster TDAP)	___/ ___/ ___ 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	Titer ☐ Pos ☐ Neg ___/ ___/ ___ Mo Day Yr

RECOMMENDED BUT NOT REQUIRED			
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: ____/____/_____ Student ID Number: _____
MM DD YYYY

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER. TB screening must be completed within six months.

Based on the guidelines published by the American College Health Association, the recommendations from the Centers of Disease Control (CDC), and the American Thoracic Society, Tuberculosis Screening is required within the last six months primarily by conducting a Risk Assessment. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at www.cdc.gov/nchstp/tb/pubs/corecurr/.

Please answer the following questions. If the student is at low risk, a TST or QFT-TB test is not required for entrance into college.

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.

2. Is the student a member of a high-risk group or is the student entering the Health Profession (nursing student)? ☐ **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, place tuberculin skin test (Mantoux only: Inject 0/1 ml of purified Protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] Intradermally into the volar [inner] surface of the forearm.) or draw QFT-TB test. A history of BCG vaccination should not preclude testing of a member of a high-risk Group.

3. Has the student lived or traveled (spent 6 weeks or more) in countries where TB is endemic? ☐ **YES** ☐ **NO**

Includes those students who have arrived within the past 5 years from countries **OTHER** than those on the following list: Albania, American Samoa, Andorra, Antigua and Barbuda, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turks and Caicos Islands, United Arab Emirates, United Kingdom, United States Virgin Islands, West Bank and Gaza Strip, United States of America

IF NO to #1, #2, & #3, TST, QFT-TB, or Chest X-Ray are not required. No further evaluation is required. **Please sign below.***

IF YES to either #1, #2 or #3, student should undergo TST or have QFT-TB test. If either screening test is positive, Chest X-Ray is required. A course of INH is recommended by CDC. Please record results in space below and sign.*

DOCUMENTATION OF TUBERCULIN SKIN TESTING, QFT-TB Test, AND/OR CHEST RADIOGRAPHY*

*Based on assessment criteria outlined above. **TB screening must be preformed within the last six months.**

A. **Tuberculin Skin Test**

Date given: ____/____/_____ Date read: ____/____/_____ Result: _____mm
MM DD YYYY MM DD YYYY (Record actual mm of induration, transverse diameter; if no induration, write "0")

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

B. **QuantiFERON Tb Test (QFT-TB)** Date obtained: ____/____/_____ **Result:** ☐ Positive ☐ Negative

C. **Chest X-Ray** (Required if Tuberculin Skin test or QFT-TB is positive.) Must have been performed no longer than **6 months** prior to admission):

Result: Please attach a copy of the chest X-Ray report in English.

Reason for CXR ☐ High Risk ☐ Pos PPD ☐ Pos QFT

Date of chest x-ray:____/____/_____ CXR ☐ Negative ☐ Positive

INH Initiated ☐ Date _____X_____months INH course completed ☐ YES ☐ NO
MM DD YYYY

Initial if INH Refused _____

(Signature required as validation of correct information for TB assessment only.)

***HEALTH CARE PROVIDER SIGNATURE**

Printed Name _____ Phone _____

Address _____

Signature_____ Date _____

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.)

- **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.)

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

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