

**Please print the following pages.**

After completing your health and immunization record, return to Health and Counseling Services. If you have any questions, please contact Health and Counseling Services at (540) 362-6444.

*Health and Counseling Services*

## Required Medical Information

Every new full-time, traditional, adult Horizon, and transfer undergraduate student entering the university is **REQUIRED** to complete and return the health and immunization record located in this packet. The physical exam, medical history, and immunizations are required. The physical examination must be within twelve months of entering Hollins. The **only exception** for this requirement is a full-time **Horizon** student (non-residential) who prefers to sign a waiver opting not to use Health and Counseling Services on campus. To obtain this form, adult Horizon students should contact Health and Counseling Services at 540-362-6444.

**Immunization Record Part B (Based on national guidelines and Virginia law)**

Registration will be blocked if you do not comply with immunization requirements. Section I must be completed by all students. Section II should be carefully reviewed for "recommended" vaccines. **Signature** of licensed health care provider or certification from health agency or clinic at the end of **both** the immunization records and tuberculosis screening is required.

**Proof of insurance** is **required** for all full-time undergraduate students, including adult Horizon students, at the beginning of **each** academic year (see pg. 1 pt. 7). If you do not provide proof of insurance by the August 2 deadline, you will be **automatically** enrolled in the Markel insurance plan offered through Hollins, and charged a **non-refundable** amount of \$715.

**PLEASE BE SURE YOUR MEDICAL COVERAGE IS VALID IN THE ROANOKE VALLEY AND ALSO VALID FOR THE 2004-2005 ACADEMIC YEAR.**

*Please include copies of all appropriate insurance cards with the health form.*

**Note:** This office does not file insurance claims.

Completed health and immunization records are to be returned to the **Health and Counseling Services**. If you have any questions, please contact Health and Counseling Services at (540) 362-6444.

**Students will not be allowed to register for classes until the Health and Immunization Record is complete.**

Deadline for submitting your Health and Immunization Record is  
**Monday, August 2, 2004**

# Health and Immunization Record

Completion of this form is a requirement for registration.

If you are transferring from another school that has completed records, please have them mailed to: Hollins University/ Health and Counseling Services, P. O. Box 9644, Roanoke, VA 24020-1644. For questions: (540) 362-6444, Fax (540) 362-6273, or e-mail rfoster@hollins.edu.

**PART A** Personal Health History (all information is for the exclusive use of the Health and Counseling Services staff and will be kept strictly confidential)

1. Name \_\_\_\_\_  
Last First Middle

Home Address City/Town State Zip Code

Home Phone (\_\_\_\_) \_\_\_\_\_

2. Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ 3. Social Security No. \_\_\_\_-\_\_\_\_-\_\_\_\_  
Mo Day Yr

4. Matriculation date: Fall 20\_\_ Spring 20\_\_ First year\_\_ Transfer\_\_

5. Name State of Health Occupation Place of Employment Work No.

Father

Mother

6. Whom to Notify in Case of an Emergency:

Name Relationship

Home Phone Work Phone

7. Proof of Health Insurance – **REQUIRED** Please submit a COPY of your valid health insurance card.

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber Name \_\_\_\_\_

My insurance is valid in the Roanoke Valley

8. Authorization for Treatment:

*In case of serious illness or accident, I give Hollins University or its representative(s) permission to secure medical and/or surgical care to include transportation to a physician or hospital of their choice, examination, medication and surgery that is considered necessary for my good health. I agree to pay all medical costs. In the event of a non-serious condition requiring minor care, I approve of care by the University's Physician and/or Registered Nurses.*

Student Signature (or) Parent/Guardian Signature (if under the age of 18)

Date: \_\_\_\_\_

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Please return all Health forms to:  
Health Services, P.O. Box 9644, Hollins University, Roanoke, VA 24020-1644  
Rita Foster, director health services, (540) 362-6298 • fax (540) 362-6273, e-mail: rfoster@hollins.edu

9. **Personal History** (please answer all questions)

**Operations/Hospitalizations** (list type of surgery or hospital admission and year)

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**Allergies** (circle all that apply)

Penicillin or Ampicillin

Sulfa

Aspirin

Foods

Other Drugs

Insects

Pollen

Dust

Mold

**Medications** (list all medications taken on a regular or frequent basis. Include vitamins, birth control pills, over-the-counter medications, and allergy injections):

Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Medication \_\_\_\_\_

Dosage \_\_\_\_\_

**HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

**Check all that apply and give details below:**

- |  |   |
|--|---|
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Head injury/concussion             |
| <input type="checkbox"/> Athletic or joint injuries    | <input type="checkbox"/> Irritable bowel/spastic colon      |
| <input type="checkbox"/> Asthma/allergies              | <input type="checkbox"/> Recurrent bladder/kidney infection |
| <input type="checkbox"/> Cancer/Hodgkin's              | <input type="checkbox"/> Severe anxiety/depression          |
| <input type="checkbox"/> Frequent colds/bronchitis     | <input type="checkbox"/> Substance abuse                    |
| <input type="checkbox"/> Chronic indigestion/ulcers    | <input type="checkbox"/> Epilepsy/seizure disorder          |
| <input type="checkbox"/> Frequent ear/sinus infections | <input type="checkbox"/> Sexual assault/abuse               |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Anemia/bleeding trait              |
| <input type="checkbox"/> Dizzy or fainting spells      | <input type="checkbox"/> Menstrual problems                 |
| <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Chicken pox                        |
| <input type="checkbox"/> Chronic headaches/migraines   | <input type="checkbox"/> Breast lumps                       |
| <input type="checkbox"/> Heart murmur/palpitations     | <input type="checkbox"/> Anorexia/bulimia                   |
| <input type="checkbox"/> Weight loss/gain ? 10 lbs.    | <input type="checkbox"/> Hepatitis                          |

Details: \_\_\_\_\_

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Do you smoke cigarettes? \_\_\_ Yes \_\_\_ No

Do you have any physical problems that require special services: \_\_\_ housing \_\_\_ parking \_\_\_ dietary

If so, explain: \_\_\_\_\_

Have you received treatment or counseling or participated in a support group for emotional problems, an eating disorder, or substance abuse (give details)?

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# Immunization Record

Name \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_  
Date of Entry \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Mo Yr Mo Day Yr

In compliance with Virginia State law, Hollins University **requires** entering students to provide immunization documentation of the diseases listed below:

**PART B TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. All information must be in English.**

## Section I

### a. TETANUS-DIPHTHERIA

1. Tetanus-Diphtheria booster must be within the last ten years \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr

### b. M.M.R. (Measles, Mumps, Rubella) (Two doses required)

1. Dose 1 given at age 12-15 months or later #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr

2. Dose 2 given at age 4-6 years or later, and at least one month after first dose #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr

### c. POLIO

Primary series completed: Yes \_\_\_\_\_ No \_\_\_\_\_ Last Booster: Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr

### d. HEPATITIS B

1. Completion of at least one of three **required** doses prior to registration. Remainder completed per scheduled doses.

Dose #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr Dose #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr Dose #3 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr

### e. PROOF OF FREEDOM FROM TUBERCULOSIS - **REQUIRED FOR ALL INTERNATIONAL STUDENTS - U.S. STUDENTS ENCOURAGED TO PROVIDE.**

Proof of freedom from tubercular disease (dates of test must be within 6 months prior to attendance at HU)

Mantoux Skin Test Date Given \_\_\_\_\_ Date Read \_\_\_\_\_ Results \_\_\_\_\_ (record in millimeters)  
Positive PPD (chest X-ray and report enclosed) Date Taken \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

**PHYSICIAN OR PUBLIC HEALTH OFFICIAL VERIFICATION: To the best of my knowledge, this person has had screening for proof of freedom from tubercular disease as noted above.**

Physician Name (print or stamp) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## Section II

Based on guidelines from the American College Health Association (ACHA), the following immunizations are **recommended**, not required, and are offered by Health & Counseling Services. Please consult your personal physician or Health & Counseling Services if you have any questions about these immunizations.

### a. VARICELLA (chicken pox)

History of Disease: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Immunizations: Dose #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr Dose #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr

### b. MENINGITIS (MENINGOCOCCAL) VACCINE: The risk of meningitis and meningococcal infection may be increased in some subsets of college students. Health & Counseling Services can provide the vaccine.

Date received: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr

### c. INFLUENZA (annual immunization recommended to avoid disruption to academic activities.)

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Yr

**HEALTH CARE PROVIDER:** (signature required as validation of correct information for immunizations and TB assessment)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date: \_\_\_\_\_



Student's Name: \_\_\_\_\_

**PART C Physician's Health Evaluation** (exam twelve months prior to entering Hollins University)

**TO THE EXAMINING PHYSICIAN:** This student has been accepted. Please review the student's history and complete the physician's form. Please comment on all abnormal answers. The information supplied will be used only as a background for providing health and mental health care, if this is necessary. This information is strictly for the use of the Health and Counseling Services and will not be released without student consent.

**Exams by parent or legal guardian not accepted**

Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Height (inches) \_\_\_\_\_ Weight (lbs.) \_\_\_\_\_ Hemoglobin \_\_\_\_\_ or Hematocrit \_\_\_\_\_

Corrected vision \_\_\_\_\_ Hearing \_\_\_\_\_ Urinalysis \_\_\_\_\_

Right 20/ \_\_\_\_\_ Right \_\_\_\_\_ Sugar \_\_\_\_\_ Micro (if indicated) \_\_\_\_\_

Left 20/ \_\_\_\_\_ Left \_\_\_\_\_ Albumin \_\_\_\_\_

Other \_\_\_\_\_

**PLEASE INDICATE ANY ABNORMALITIES IN THE FOLLOWING:**

	Normal	Abnormal		Normal	Abnormal
Skin			Breasts		
Lymph			Lungs		
Eyes			Heart		
Ears			Abdomen		
Nose			Back/spine		
Mouth/throat			Genitalia		
Neck/thyroid			Extremities		
			Neurological		

**RECOMMENDATIONS FOR PHYSICAL ACTIVITY: PE, intramurals, and intercollegiate sports**

Limited  Unlimited

How long have you known this student? \_\_\_\_\_

Is the patient now under treatment for any medical or emotional condition?  Yes  No

Does student take any medications regularly?  Yes  No

Do you have any recommendations regarding the care of this student?  Yes  No

Comments \_\_\_\_\_

\_\_\_\_\_  
Health Care Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Health Care Provider's Phone Number

\_\_\_\_\_  
Please Print Health Care Provider's Name/Address

\_\_\_\_\_  
Health Care Provider's FAX Number

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# Prospective Athlete New Students (First Year/Transfer)

As a prospective athlete for Hollins University, you will be **required** to have a **complete physical exam** before you participate in any athletic activities at Hollins University.

The staff of Health and Counseling Services works hard to maintain strict confidentiality. However, in order for you to perform safely as an athlete, the athletic department requests knowledge of certain information. This includes information concerning drug and alcohol use, current medications, allergies (e.g., bee stings, drug allergies), need for corrective lenses, and history of any medical condition or injury that may need to be monitored during your participation in sports.

Your freshman or transfer **Health and Immunization Record** form will contain information to be released to the athletic department. It will be your responsibility to inform us if you do not wish to release any specific information.

It is because of our strong concern for confidentiality that we want you to be aware of this procedure. Our aim is to help you to safely participate in the Hollins University athletic program. We believe firmly in physical fitness for all and will work with you to reach that goal.

**I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT. (Please return this statement and your Health and Immunization Record to Health and Counseling Services.)**

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**Signature**

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**Date**

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**Please Print**