



Health and Immunization Record

Completion of this form is a requirement for registration.

If you are transferring from another school that has your completed records, please have them mailed to: Hollins University, Health and Counseling Services, P. O. Box 9644, Roanoke, VA 24020-1644. Questions: call (540) 362-6444, fax (540) 362-6273.

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 (____) _____ Student cell phone (____) _____

Race _____ Marital status _____

2. Date of birth ____/____/____ 3. Social security number ____-____-____
Mo Day Yr

4. Matriculation date: Fall 20____ Spring 20____ First-Year____ Transfer____

5. Parent Information:

Father's name Mother's name

State of health State of health

Occupation Occupation

Place of employment Place of employment

Work phone Work phone

6. Whom to Notify in Case of an Emergency:

Name Relationship

Home phone Work phone

7. 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 physician, nurse practitioner, and/or registered nurse.

Student signature (or) parent/guardian signature (if under the age of 18)

Date

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

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

Allergies (circle all that apply) Penicillin or Ampicillin
Sulfa Aspirin Foods _____
Insects Pollen Dust Mold Other Drugs _____

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 _____

If you are currently prescribed medication for ADD/ADHD, a letter from your physician with documentation of diagnosis and medication dosage are required.

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Check all that apply and give details below:

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

Details:

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)?

Part B: Tuberculosis Screening

(Required of all students)

Name: _____ Date of birth: _____ Social security number: _____

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

Based on the guidelines published by The American College Health Association, the recommendations from the Centers for Disease Control (CDC) and the American Thoracic Society, Tuberculosis Screening is required within six months of college entry 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 the following website: www.cdc.gov/nchstp/tb/pubs/corecurr/. Please answer the following questions. If the student is at low risk, a PPD 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, 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**? 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 bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone \geq 15mg/d for \geq 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.) A history of BCG vaccination should not preclude testing of a member of a high-risk Group. If PPD is not placed, a chest x-ray is required (see **B** to record x-ray result)

3. Has the student **lived or travelled** (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: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

If **NO** to #1, #2, & #3, PPD and Chest X-Ray are not required. No further evaluation is required, please sign below.

If **YES**, Students should undergo **tuberculin skin test or Chest X-ray**. (See # 2 Above)

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY*

* (Based on assessment criteria outlined above)

A. Tuberculin Skin Test (must have been performed within the last six months)

Date given: _____ Date read: _____ Result: _____ mm
Mo Day Yr (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. Chest X-Ray (required if Tuberculin Skin test is positive or if PPD has not been placed but patient is at risk of disease; must have been performed within the last six months):

Result: Normal Abnormal
Date of chest x-ray: _____ INH Initiated Date _____ X _____ months

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

Name: _____ Address: _____
Signature: _____ Phone: _____ Date: _____

(TB screening must have been performed within the last six months)

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 _____

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.)

Signature

Date

Please print