



Health and Immunization Record

COMMONWEALTH OF VIRGINIA LAW AND/OR HOLLINS UNIVERSITY REQUIRES THAT THE HEALTH RECORD FORM AND CERTIFICATE OF IMMUNIZATION BE COMPLETED AND SUBMITTED BY ALL RESIDENTIAL STUDENTS TO THE STUDENT HEALTH & COUNSELING SERVICES CENTER PRIOR TO ENROLLMENT AT HOLLINS UNIVERSITY

Students are directed to submit their Health and Immunization Record using the Hollins University Health Record Submission Form. If you encounter difficulties using the form, please email or call Health & Counseling Services.

Phone: (540) 362-6444 Email: hcs@hollins.edu

Completed forms must be returned no later than July 1 for fall semester and December 1 for spring semester

Section I: Personal Information

Name Last First Middle Student ID# (Student ID # is Required to Process this form.)

Date of Birth Mo Day Year Sex Marital Status Race

Local Address (If living off campus) No. & Street City State Zip

Permanent Address No. & Street City State Zip

Email Address Home Phone Cell Phone

Family Physician Name Address

Medical Insurance - Subscriber Name: DOB:

Subscriber employer:

Please include a copy (front & back) of your insurance card and/or prescription card. We will need this information for prescriptions and any outside referrals.

Medical History (Confidential)

1. List any chronic mental or physical health condition for which you are being treated. Please also list hospitalizations/surgeries:

2. List any 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 Health & Counseling Services permission to treat me whenever I present myself to the Center.

Student's Signature Date

Under 18: Statement must be signed by parent of guardian if student is under 18 years of age.

I/we, the parents of hereby authorize and give permission to the Health & Counseling Services to treat my/our child whenever my/our child presents to the Center.

Parent/Guardian Signature Date

## Section II: Immunization Record **IMPORTANT REQUIREMENT**

Commonwealth of Virginia Law and Hollins University require all students to submit a health record with documented immunizations. This MUST be signed by a health care provider, and all immunizations must be current.

**NOTE:** In case of an incomplete immunization record, preregistration for the following semester will be blocked.

| REQUIRED IMMUNIZATIONS   | VACCINE DOSES ADMINISTERED   |                                       |  |  |
|--|--|---------------------------------------|--|--|
| <b>HEPATITIS B</b><br>(For combined Hep. A + B, do not use this line. Instead, check here: _____ and complete the appropriate line in "Recommended")<br>Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg _____ / _____ / _____<br>Mo Day Yr | #1<br>____ / ____ / ____<br>Mo Day Yr  | #2<br>____ / ____ / ____<br>Mo Day Yr | #3<br>____ / ____ / ____<br>Mo Day Yr  | Date series completed<br>____ / ____ / ____<br>Mo Day Yr                               |
| <b>MENINGOCOCCAL VACCINE</b><br>Must have at least one Men ACWY vaccine after age 16.  | #1<br>____ / ____ / ____<br>Mo Day Yr  | #2<br>____ / ____ / ____<br>Mo Day Yr |  |  |
| <b>MEASLES, MUMPS, RUBELLA (MMR)</b><br>Students born before 1957 are not required to have a second MMR vaccination.   | #1<br>____ / ____ / ____<br>Mo Day Yr  | #2<br>____ / ____ / ____<br>Mo Day Yr | Titters only needed if dates unavailable<br>Measles Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg _____ / _____ / _____<br>Mo Day Yr<br>Mumps Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg _____ / _____ / _____<br>Mo Day Yr<br>Rubella Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg _____ / _____ / _____<br>Mo Day Yr |  |
| <b>TETANUS DIPHTHERIA Adult pertussis (TDAP)</b><br>(Within last 10 years)   | ____ / ____ / ____<br>Mo Day Yr  |                                       |  |  |
| <b>POLIOMYELITIS (OPV or IPV)</b>  | Have you completed the series?<br><input type="checkbox"/> yes <input type="checkbox"/> no |                                       | _____ / _____ / _____ Date completed<br>Mo Day Yr  |  |
| <b>VARICELLA</b><br>(two doses one month apart for adults with no history of disease)  | #1<br>____ / ____ / ____<br>Mo Day Yr  | #2<br>____ / ____ / ____<br>Mo Day Yr | <input type="checkbox"/> Had Disease<br>Date : _____ / ____ / ____   | Titer <input type="checkbox"/> Pos <input type="checkbox"/> Neg<br>_____ / ____ / ____ |

| RECOMMENDED - PLEASE INCLUDE VACCINATION DATES                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| COVID-19 VACCINE  | #1<br>____ / ____ / ____ | #2<br>____ / ____ / ____ | #3<br>____ / ____ / ____ |
| HEPATITIS A   | #1<br>____ / ____ / ____ | #2<br>____ / ____ / ____ |                          |
| Combined Hepatitis A + B Vaccine<br>Hepatitis B is required. See above. | #1<br>____ / ____ / ____ | #2<br>____ / ____ / ____ | #3<br>____ / ____ / ____ |
| HPV, Quadrivalent or Bivalent (age 26 and under)                        | #1<br>____ / ____ / ____ | #2<br>____ / ____ / ____ | #3<br>____ / ____ / ____ |
| PNEUMOCOCCAL VACCINE (high-risk persons)                                | #1<br>____ / ____ / ____ |                          |                          |

| HEALTH CARE PROVIDER   |
|--|
| <b>*This form will not be accepted if not signed by a health care provider</b> |
| Printed Name _____ Phone _____<br>Address _____<br>Signature _____ Date _____  |

|   |
|---|
| <b>†MEDICAL EXEMPTION</b><br><input type="checkbox"/> DTP <input type="checkbox"/> Td <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Measles <input type="checkbox"/> Rubella <input type="checkbox"/> Mumps <input type="checkbox"/> Meningococcal Vaccine <input type="checkbox"/> OPV<br>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.<br>The vaccine(s) is (are) specifically contraindicated because _____<br>This contraindication is <input type="checkbox"/> permanent (or) <input type="checkbox"/> temporary and expected to preclude immunization until _____<br>Signature of Physician or Health Department Official _____ Date _____ |
|---|

|  |
|--|
| <b>†Religious Exemption:</b> Any student who objects on the grounds that administration of immunizing agents conflicts with religious beliefs or practices shall be exempt from the immunization requirements unless an emergency or epidemic 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 \_\_\_\_\_

**TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER. TB screening must be completed within the past six months. Please answer all three of the following questions with "YES" or "NO."**

- 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**, obtain QFT (preferred) or perform TST

**QFT-TB** Date obtained: \_\_\_/\_\_\_/\_\_\_ **Result:**  Positive  Negative

**OR TST:** Date given: \_\_\_/\_\_\_/\_\_\_ Date read: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_\_\_ mm (transverse induration)

**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 (if symptoms):

Date: \_\_\_/\_\_\_/\_\_\_ **Result:**  Normal If abnormal CXR, return to Question 1 - yes

If normal CXR, INH initiated Date: \_\_\_/\_\_\_/\_\_\_ Completed: \_\_\_/\_\_\_/\_\_\_

- 3. Was the student born in or has the student spent 3 or more months in a country 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**, please sign below.\*

**If YES**, obtain QFT: Date obtained: \_\_\_/\_\_\_/\_\_\_ **Result:**  Positive  Negative (If negative, sign below)

If positive without symptoms, INH initiated Date: \_\_\_/\_\_\_/\_\_\_ Completed: \_\_\_/\_\_\_/\_\_\_

**HEALTH CARE PROVIDER**

**\*Signature required as validation of correct information for TB assessment**

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

Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Section III: Physician's Health Evaluation** (exam within twelve months of entering Hollins University)

**TO THE EXAMINING PHYSICIAN:** 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*

|                       |                            |                |  |
|-----------------------|----------------------------|----------------|--|
| Height (inches) _____ | <u>Un-Corrected vision</u> | <u>Hearing</u> |  |
| Weight (lbs.) _____   | Right 20/ _____            | Right _____    | <b>*Please complete the following lab work<br/>if indicated*</b> |
| Temperature _____     | Left 20/ _____             | Left _____     |  |
| Blood Pressure _____  | <u>Corrected vision</u>    |                | Urinalysis: Neg _____ Pos _____                                  |
| Pulse _____           | Right 20/ _____            |                | Hemoglobin/Hematocrit _____                                      |
|                       | Left 20/ _____             |                |  |

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:       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 \_\_\_\_\_

If patient is prescribed medication for ADD/ADHD, a letter from the physician with documentation is **required**.

|  |   |
|--|---|
| <b>HEALTH CARE PROVIDER</b>  | <b>*Signature required as validation of physical exam</b> |
| <b>*This form will not be accepted if not signed by a health care provider</b> |   |
| Printed Name _____   | Phone _____   |
| Address _____  |   |
| Signature _____  | Date _____  |

# Continuation of Care

Hollins University is committed to supporting students in their pursuit of well-being from a holistic perspective. If your student is currently being treated for a physical or mental health condition, we want to help with their transition to campus life. Before your student comes to Hollins, please take these steps:

- If your student takes prescription medications, please make sure they have refills to get them started. We have a Nurse Practitioner, Medical Doctor and Psychiatrist who may be able to refill these medications, but having refills will help to avoid gaps in care.
- If your student takes medications for ADD/ADHD, obtain records from the current physician and have the student contact Health Services upon arrival to campus to schedule an appointment with the Medical Doctor.
- If you believe your student needs medications for ADD/ADHD but they have not been diagnosed, please schedule an appointment with your doctor at home. While our Medical Doctor can prescribe ADD/ADHD medications, we do not diagnose ADD/ADHD.
- If your student sees a psychiatrist at home, please obtain records from their current psychiatrist. Your student will need to see a counselor on campus for a referral to our psychiatrist.
- If your student has not had all the required vaccines, she/they will need to receive these prior to arrival to campus.
- Students with a completed health chart are eligible for free counseling services. If your student needs additional counseling support, our counselors will facilitate a referral to a local provider.

If you would like to discuss any physical or mental health conditions with our office before your student arrives on campus, please fill out the form below and someone from the Health and Counseling Center will contact you.

**Student name:** \_\_\_\_\_

***Would like more information about:***

Health services (please specify): \_\_\_\_\_

Counseling

Treatment for ADD/ADHD

Psychiatric Services

Other (please specify): \_\_\_\_\_

Preferred method of contact:

Email : \_\_\_\_\_  Phone: \_\_\_\_\_

# To Be Completed By

## New Student Prospective Athlete

As a prospective student-athlete for Hollins University, you are **required** to have a **complete physical exam** before you can participate in any athletic program activities at Hollins University.

The staff of the Health & Counseling Services Center is committed to maintaining strict confidentiality. However, in order for you to perform safely as a student-athlete, the athletic department may request knowledge of certain confidential health information and/or conditions. This may include information such drug and alcohol use, current medications, allergies (e.g., bee stings, drug allergies), need for corrective lenses, and/or history of any medical condition or injury that may need to be monitored during your participation in collegiate sports.

We believe firmly in the benefits of physical fitness for all and will support you to help you reach your goals as a student-athlete. Our goal is to help you to safely participate in athletic programs and activities, which may require confidentially providing information to the athletic department as needed in order to support that goal.

Your first-year or transfer **Health and Immunization Record** form contains information that may be confidentially released to the athletic department in order for you to safely participate in athletic programs. It will be your responsibility to inform the Health & Counseling Services Center if you do not wish to release specific information to the athletic department.

**I HAVE FULLY READ, UNDERSTAND AND AGREE TO THE ABOVE:**

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**Student Signature**

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**Date**

---

**Parent/Guardian Signature if student under 18**

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**Date**

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**Print Full Name**

**Please return this document along with your Health and Immunization Record to Health and Counseling Services**