EMORY & HENRY COLLEGE

INTERNAL USE ONLY:
Forward to
Health Center

Immunization Record and Medical Information Form

Information contained in this six-page form will not affect your admission status and is strictly for the use of E&H College Health Services. Varsity athletes and members of certain affinity groups: To meet the athletic training office requirement, please upload your completed form into the ARMS system and submit per instructions on page 6. The information will be considered confidential and will not be released to anyone without your knowledge and consent. Information supplied will be used as a point of reference in case of future illness or need for ongoing medical treatment. Please complete pages 1, 2 and 4, answering all personal history and TB screening questions before your appointment with your healthcare provider for the physical evaluation, page 3. Return of this completed form entitles you to be seen at no charge during E&H Health Center doctor/nurse practitioner hours for students. Please complete the entire form paying careful attention to required healthcare provider, student, and parent signatures. Questions: 276-944-6219

NOTICE OF PRIVACY PRACTICES – Please read and sign this statement

Emory & Henry College Student Health Center complies with HIPAA (Privacy Practices) regulations. A full list of these regulations may be found on our website, posted at the Student Health Center, or available in print upon request. Federal law requires that we inform you of this privacy statement.

Student Signature _____ Printed Student Name _____ Date Signed _____

Patient Information

LAST NAME (PRINT) _____ FIRST NAME _____ MIDDLE _____ CELL PHONE # _____

HOME ADDRESS (NUMBER & STREET) _____ CITY/TOWN _____ STATE _____ ZIP CODE _____ HOME PHONE # _____

Date of Birth _____ Place of Birth _____ Age _____ Gender _____ Race _____ Marital Status _____

Parent/Guardian 1 _____
Cell or Work # _____

Parent/Guardian 2 _____
Cell or Work # _____

Insurance: _____
Group Number: _____
Policy Number: _____
Address: _____
Telephone: _____
Policy holder name: _____ Date of Birth: _____

Admission status:

- ☐ First-year
- ☐ Transfer
- ☐ Readmission

Date of Entrance:

- ☐ Fall
- ☐ Spring
- ☐ Summer

20___

ATTACH A COPY OF **FRONT** AND BACK OF INSURANCE CARD.

Family History

	AGE	STATE OF HEALTH	DEATH AGE AT	CAUSE OF DEATH	HAVE ANY OF YOUR RELATIVES EVER HAD THE FOLLOWING:	YES	NO	RELATIONSHIP
Father					Asthma, Hay Fever			
Mother					Arthritis			
Brother(s)					Diabetes			
					Epilepsy, Convulsions			
					Heart Disease			
Sister(s)					Kidney Disease			
					Stomach Disease			
					Tuberculosis			

Personal History

If you have ever had any of the following conditions or symptoms, please place a check mark in the appropriate box.

☐	ADHD/ADD	☐	Eating Disorders	☐	Pain/Pressure in Chest
☐	Acne/Skin Problems	☐	Female Only	☐	Palpitations (Heart)
☐	Allergy (if so, list)	☐	Irregular Period	☐	Pneumonia
☐	Medications	☐	Severe Cramps	☐	Recent Gain or Loss of Weight
☐	Seasonal	☐	Excessive Flow	☐	Recurrent Colds
☐	Foods (types)	☐	Eye Trouble/Glasses/Contacts	☐	Rheumatic Fever or Heart Murmur
☐	Anemia/Blood Disorder	☐	Frequent Anxiety/Worry/Nervousness	☐	Scarlet Fever
☐	Appendectomy	☐	Frequent Depression	☐	Seizures
☐	Arthritis	☐	Gallbladder Trouble or Gallstones	☐	Sexually Transmitted Disease
☐	Asthma	☐	Gum or Tooth Trouble	☐	Shortness of Breath
☐	Back Problems	☐	GYN Surgery	☐	Sinusitis
☐	Cardiac Problems	☐	Headaches Frequent/Migrane/Recurrent	☐	Stomach or Intestinal Trouble
☐	Chicken Pox Date _____	☐	Head Injury with Unconsciousness	☐	Surgery
☐	Chronic Cough	☐	Hernia Repair	☐	Thyroid Problems
☐	Concussion(s)	☐	Hepatitis/Jaundice	☐	Tonsillectomy
☐	COVID-19 Date(s) _____	☐	High or Low Blood Pressure	☐	Tuberculosis
☐	Dental Appliances	☐	Insomnia	☐	Tumor, Cancer, Cyst
☐	Diabetes	☐	Kidney Stones	☐	Urinary Infections/Problems
☐	Disease or Injury of Joints/Bone	☐	Measles	☐	Other
☐	Dizziness, Fainting	☐	Mononucleosis (Mono)	☐	Other
☐	Drug/Alcohol Problem	☐	Mumps	☐	Other
☐	Ear, Nose, Throat Trouble	☐	Neurological Disorder	☐	Other

Explain Conditions Checked:

Has your physical activity been restricted during the past five years? (Give reasons and durations.) ☐ yes ☐ no

Do you take any medication? If yes, give name and dosage on attached sheet. ☐ yes ☐ no

Have you had any illnesses or injuries requiring hospitalization? (Give details.) ☐ yes ☐ no

Have you received any treatment or counseling for a nervous condition, personality or character disorder, or emotional problems? (Give diagnosis and dates of treatment.) ☐ yes ☐ no

Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years (other than routine checkups)? ☐ yes ☐ no

Are you on medication for cramps or the regulation of periods? (If so, name) ☐ yes ☐ no

Have you been rejected or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons.) ☐ yes ☐ no

Student's Signature Date

MD/DO/NP/PA Signature (Acknowledging Review) Date

Physical Evaluation

To the Examining Physician: Please review the student's history (page 2) and complete this physicial form. Please comment on all positive answers. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect their status and will be used only as a background for providing health care.

_____ Sex: ❑ Male ❑ Female
LAST NAME FIRST NAME MIDDLE

Height: _____ feet _____ inches Weight: _____ lbs. Overweight ☐ Underweight ☐

Corrected Vision: Right-20/_____ Left-20/_____ Hearing: R _____ L _____

Pupils: Equal ☐ Unequal ☐

Pulse: _____ Resp: _____ Temperature: _____ Blood Pressure: _____

Urinalysis: glucose: _____ protein: _____ micro: _____ Hemoglobin (gm/dL) or Hematocrit (%): _____

ARE THERE ABNORMALITIES OF THE FOLLOWING SYSTEMS? DESCRIBE FULLY. USE ADDITIONAL SHEET IF NEEDED.				
❑ yes	❑ no	Head, Ears, Nose, or Throat		
❑ yes	❑ no	Respiratory		
❑ yes	❑ no	Cardiovascular		
❑ yes	❑ no	Gastrointestinal		
❑ yes	❑ no	Hernia		
❑ yes	❑ no	Eyes		
❑ yes	❑ no	Genitourinary	Male:	Female:
❑ yes	❑ no	Musculoskeletal		
❑ yes	❑ no	Metabolic/Endocrine		
❑ yes	❑ no	Neuropsychiatric		
❑ yes	❑ no	Skin		
❑ yes	❑ no	Other:		

General Appearance / General Comments _____

Prescription medication taken regularly: _____

Over-the-counter medication taken regularly: _____

Recommendations for physical activity (PE, intramurals) and participation in varsity sports. ❑ Unlimited ❑ Limited

Do you have any recommendations regarding the care of this student? ❑ yes ❑ no

Is the patient now under treatment for any medical or emotional condition? ❑ yes ❑ no

Varsity Athlete Sport: _____

Per NCAA rules, all athletes must show proof of Sickle Cell Trait Testing from either a newborn panel, a hemoglobin solubility test, or a current lab blood draw sickle cell trait screening test.

Documentation is required. Copy showing result must be attached.

Tuberculin (TB) Screening Questionnaire is required. Please complete pages 4 and 5 (including signature).

MD/DO/NP/PA Signature Print Last Name Date

Address City State Zip Code Office Phone

Name: _____ Date _____

Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? ❑ Yes ❑ No

(If yes, please CHECK the country, below)

- ☐ Afghanistan
- ☐ Algeria
- ☐ Angola
- ☐ Anguilla
- ☐ Argentina
- ☐ Armenia
- ☐ Azerbaijan
- ☐ Bangladesh
- ☐ Belarus
- ☐ Belize
- ☐ Benin
- ☐ Bhutan
- ☐ Bolivia (Plurinational State of)
- ☐ Bosnia and Herzegovina
- ☐ Botswana
- ☐ Brazil
- ☐ Brunei Darussalam
- ☐ Bulgaria
- ☐ Burkina Faso
- ☐ Burundi
- ☐ Cotê d'Ivoire
- ☐ Cabo Verde
- ☐ Cambodia
- ☐ Cameroon
- ☐ Central African Republic
- ☐ Chad
- ☐ China
- ☐ China, Hong Kong SAR
- ☐ China, Macao SAR
- ☐ Colombia
- ☐ Comoros
- ☐ Congo
- ☐ Democratic People's Republic of Korea
- ☐ Democratic Republic of the Congo
- ☐ Dominican Republic
- ☐ Ecuador
- ☐ El Salvador
- ☐ Equatorial Guinea
- ☐ Eritrea
- ☐ Eswatini
- ☐ Ethiopia
- ☐ Fiji
- ☐ Gabon
- ☐ Gambia
- ☐ Georgia
- ☐ Ghana
- ☐ Greenland
- ☐ Guam
- ☐ Guatemala
- ☐ Guinea
- ☐ Guinea-Bissau
- ☐ Guyana
- ☐ Haiti
- ☐ Honduras
- ☐ India
- ☐ Indonesia
- ☐ Iraq
- ☐ Kazakhstan
- ☐ Kenya
- ☐ Kiribati
- ☐ Kyrgyzstan
- ☐ Lao People's Democratic Republic
- ☐ Latvia
- ☐ Lesotho
- ☐ Liberia
- ☐ Libya
- ☐ Lithuania
- ☐ Madagascar
- ☐ Malawi
- ☐ Malaysia
- ☐ Maldives
- ☐ Mali
- ☐ Malta
- ☐ Marshall Islands
- ☐ Mauritania
- ☐ Mexico
- ☐ Micronesia (Federated States of)
- ☐ Mongolia
- ☐ Morocco
- ☐ Mozambique
- ☐ Myanmar
- ☐ Namibia
- ☐ Nauru
- ☐ Nepal
- ☐ Nicaragua
- ☐ Niger
- ☐ Nigeria
- ☐ Niue
- ☐ Northern Mariana Islands
- ☐ Pakistan
- ☐ Palau
- ☐ Panama
- ☐ Papua New Guinea
- ☐ Paraguay
- ☐ Peru
- ☐ Philippines
- ☐ Portugal
- ☐ Qatar
- ☐ Republic of Korea
- ☐ Republic of Moldova
- ☐ Romania
- ☐ Russian Federation
- ☐ Rwanda
- ☐ Sao Tome and Principe
- ☐ Senegal
- ☐ Sierra Leone
- ☐ Singapore
- ☐ Solomon Islands
- ☐ Somalia
- ☐ South Africa
- ☐ South Sudan
- ☐ Sri Lanka
- ☐ Sudan
- ☐ Suriname
- ☐ Tajikistan
- ☐ Thailand
- ☐ Timor-Leste
- ☐ Togo
- ☐ Tokelau
- ☐ Tunisia
- ☐ Turkmenistan
- ☐ Tuvalu
- ☐ Uganda
- ☐ Ukraine
- ☐ United Republic of Tanzania
- ☐ Uruguay
- ☐ Uzbekistan
- ☐ Vanuatu
- ☐ Venezuela (Bolivarian Republic of)
- ☐ Viet Nam
- ☐ Yemen
- ☐ Zambia
- ☐ Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence. Countries and territories with incidence rates of ≥ 20 cases per 100,000 population.

Have you resided in or traveled to one or more of the countries or territories listed above for a period of one to three months or more? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No

Have you been a resident, volunteer and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or healthcare worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above questions, Emory & Henry College requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing or further action is required.

* The significance of any travel exposure should be reviewed with a healthcare provider.

Healthcare Professional Signature _____ Date _____

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) Yes _____ No _____

History of BCG vaccination? (If yes, consider IGRA if possible.) Yes _____ No _____

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1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____ **If No, proceed to 2 or 3. If Yes, check below:**

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis) ❑ Chest pain ❑ Loss of appetite
- ❑ Unexplained weight loss ❑ Night sweats ❑ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral), and sputum evaluation as indicated.

2. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) ❑QFT-GIT ❑T-Spot ❑other_____
M D Y

Result: negative_____ positive_____ indeterminate_____ borderline_____(T-spot only)

Date Obtained ____/____/____ (specify method) ❑QFT-GIT ❑T-Spot ❑other_____
M D Y

Result: negative_____ positive_____ indeterminate_____ borderline_____(T-spot only)

3. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

**Interpretation guidelines:

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- Foreign born or travelers to the U.S. from high prevalence areas or who resided in one for a significant* amount of time
- Injection drug users
- Mycobacteriology laboratory personnel
- Residents, employees, or volunteers in high-risk congregate settings
- Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

* *The significance of the travel exposure should be discussed with a healthcare provider and evaluated.*

4. Chest X-Ray: (Required if IGRA or TST is positive. Note: a single PA view is indicated in the absence of symptoms)

Date of chest x-ray: ____/____/____ Result: normal_____ abnormal_____

Healthcare Professional Signature Date

Immunization Record

Name Date of Birth Social Security # / /

Attach a complete immunization record or fill in the following:

Vaccine	Date Injection Administered	Injection #2	Injection #3
example: MMR	*9/08/2003*	*7/10/2007*	
Coronavirus			
Hepatits A			
Hepatits B			
HPV			
Influenza		(Date of last/most recent dose)	
Meningococcal Quad			
Serogroup B Meningo			
MMR*			
Polio Series*		(Date of last dose)	
Tdap* (or Td booster)		(This dose must be within the past ten years.)	
Varicella			
Others			

All immunizations are strongly recommended. If you have had the disease(s), please note the date.
Starred immunizations are required by law.
In lieu of vaccination, proof of immunity by titer must be attached.

Please mail the completed **six-page** form to:

Admissions Office
Emory & Henry College
P.O. Box 947 • Emory, Virginia 24327-0947
Telephone: 276-944-6133

Or, fax directly:
Emory & Henry College
Health Center
Fax: 276-944-6666

You must have this form completed *no later than* July 1 (fall admission) or December 1 (spring admission).

A parent or guardian of a student under 18 years of age must sign the following statement to allow the college to authorize emergency treatment. The staff of Emory & Henry College has my permission to authorize emergency medical treatment for our son/daughter, _____.

Parent Signature Date

EMERGENCY NOTIFICATION YES ☐ NO ☐

I permit Emory & Henry College medical staff and its consultants to notify my emergency contact in the event of a serious illness or emergency.

Student Signature Date