LONGWOOD
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Required Submission of Health Record

In accordance with the Commonwealth of Virginia and the American College Health Association Immunization Guidelines 2012, Longwood University policy requires that all full time students, enrolling for the first time in any four-year public institution of higher education in this Commonwealth, must have a health history on file in the Longwood University Health Center on a Health Wellness Form. All other registered students who are not employees and pay the comprehensive fee must also have a complete Health Wellness Form on file (e.g. part-time, graduate students, International/Exchange Visiting students). This policy helps ensure the health of all students by reducing the possibility of communicable disease on the Longwood University Campus. Any Student not providing such record will be restricted from registering for his or her second semester per Longwood University Policy.

Please complete the attached Health Record and submit it directly to the University Health Center at your Orientation. It is extremely important that you do not delay in this process so that your second semester registration is not prohibited.

If you have previously attended Longwood University and have previously submitted a Student Health Record, please contact the University Health Center to confirm that they have the form on file or if any additional or updated immunization information is required. Any questions regarding a previously submitted Student Health Record will be directly answered by the University Health Center.

Longwood University Health Center

106 Midtown Ave.

Farmville, Va. 23901

Phone: 434-395-2102 Fax 434-395-2783

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Health Record Form

COMMONWEALTH OF VIRGINIA LAW AND/OR LONGWOOD UNIVERSITY REQUIRES THAT THE HEALTH RECORD FORM AND CERTIFICATE OF IMMUNIZATIONS BE COMPLETED AND SUBMITTED TO THE UNIVERSITY HEALTH CENTER PRIOR TO ENROLLMENT AT LONGWOOD UNIVERSITY.

Personal Information:

Name: _____ Student ID#: _____

Date of Birth: _____/_____/_____ Sex: _____ Marital Status: _____

Local Address: _____ Telephone: _____

Permanent Home Address: _____

Parent/Guardian Email Address: _____

In Case of Emergency, Notify: _____ Phone: _____

Family Physician: _____ Phone: _____

Medical Insurance Company: _____ Policy #: _____

Type of Plan: ☐ HMO ☐ PPO ☐ Uninsured ☐ Other

Date of Entrance to University: _____

Medical History (Confidential)

1. Name of chronic illness or major medical condition for which you are being treated. Please also list any hospitalization/surgeries: _____
   _____
2. List medications you are currently taking: _____
   _____
3. List any medication, food, or environmental substance to which you are ALLERGIC and describe allergic reaction:
   _____

Over 18: I, hereby, give the University Health Center permission to treat me whenever I present myself to the Center.

Student 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 University Health Center to treat my/our child whenever my/our child presents to the Health Center.

Signature of Parent/Guardian: _____ **Date:** _____

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Certificate of Immunization

All full-time students are required by the Code of Virginia (Section 23-7.5) to provide documentation of their immunizations by a licensed health professional. If you are unable to provide appropriate documentation, vaccines may be repeated. A registration hold for the upcoming semester will be placed if all required immunizations are not up-to-date.

Name: _____ Date of Birth: _____

Address: _____

Born in the USA? □ Yes □No If no, country of birth: _____

Student L# _____ Email: _____ Cell# _____

To be completed and signed by a licensed health-care provider

Any attached documents in a language other than English must be translated into English by the health care provider

®	= REQUIRED	
®	**Tuberculosis Screening** All students regardless of enrollment status are required to complete the tuberculosis screening form on page 3.	
IMMUNIZATIONS		
	Diphtheria, Pertussis, Tetanus (DPT)	Student has received_____doses. Last dose given on_____.
	Hepatitis A ①_____ ②_____	
®	**Hepatitis B** ①_____ ②_____ ③_____ **Or** **Hep A/B** ①_____ ②_____ ③_____ ***NURSING /ATHLETIC STUDENTS CANNOT WAIVE**	**OR** Serological confirmation of immunity. **Attach copy of lab result.** **OR** Waiver signed.
	HPV ①_____ ②_____ ③_____	HPV4 □ HPV9 □
®	**Meningococcal Vaccine** ①_____ ***One-Two doses, last dose required after 16th birthday** **OR** Waiver Signed ***NURSING/ATHLETIC STUDENTS CANNOT WAIVE**	MCV4 □ MPS4 □
	Meningococcal Group B ①_____ ②_____ ③_____	□Bexsero □Trumenba
®	**Measles, Mumps, Rubella (MMR)** ①_____ ②_____ **After first birthday** **28 Days after 1st Dose**	**OR** serological confirmation of immunity to measles, mumps, and rubella. **Attach copy of lab result.**
®	**Polio (IPV or OPV)** ①_____ ②_____ ③_____ ④_____ ***Primary series, doses at least 28 days apart with last dose after age 4 years**	***Required for 18 and under OR from countries of high risk including Afghanistan and Pakistan**
®	**Tetanus, diptheria, pertussis (Tdap) Required** within 10 years _____	**OR Tetanus, diphtheria (Td)** within 10 years _____
	Varicella (Chicken Pox) ①_____ ②_____	**OR Date of Disease** _____
	_____ **Health Care Provider or Health Department Signature**	**Date** **Phone**

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Tuberculosis Screening Form

Name: _____ DOB: _____ L#: _____

The Centers for Disease Control and the U.S. Public Health Service recommend that tuberculosis testing be performed on ALL individuals who may be at increased risk of tuberculosis disease. For more information, visit http://www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at http://www.cdc.gov/nchstp/tb/pubs/corecurr/.

1. Have you had a prior positive TB test? (If yes, you **must** complete symptom survey.) ( ) yes ( ) no
2. Have you ever been a close contact with persons known or suspected to have active TB disease ( ) yes ( ) no
3. Have you been a resident and/or employee in high risk settings such as long-term care facilities, homeless shelters, correctional facilities, or any other health care facilities? ( ) yes ( ) no
4. Have you been a healthcare worker or volunteer serving high risk clients (such as the homeless, prison settings or hospitals)? ( ) yes ( ) no
5. Have you ever injected illegal drugs? ( ) yes ( ) no
6. Do you have signs or symptoms of active TB disease: unexplained fever, weight loss, loss of appetite, night sweats, persistent cough for more than 3 weeks, and/or cough with production of bloody sputum? ( ) yes ( ) no
7. Do you have a clinical condition such as HIV, diabetes, cancer, kidney disease, silicosis, leukemia or lymphoma, chronic malabsorption syndromes, removal of part of your stomach or have been on prolonged corticosteroid or immunosuppressive therapy? ( ) yes ( ) no
8. Were you born in a country listed below and lived there for three (3) months or more? ( ) yes ( ) no
9. Have you lived in or visited any country listed below for three (3) months or more? ( ) yes ( ) no

( ) **I have answered "YES" to 1 or more of the above questions. A TB test is required. Submit results of a TB test or IGRA done in the United States within the past year.**

( ) **I have answered "NO" to ALL of the above questions. No TB test is required.**

Signature of Student or Parent/Legal Guardian: _____ **Date:** _____

Afghanistan, Algeria, Angola, Argentina, ,Armenia, Azerbaijan, Bangladesh, Belarus, Belize, Benin, Bhutan Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Burma, Cabo Verde, Cambodia, Cameroon, Central African Republic, Chad, China, Colombia, Congo, Cote d'Ivoire, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Fiji, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iran, Iraq, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Korea, Loa, Latvia, Lesotho, Liberia, Lithuania, Libya, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mexico, Micronesia, Moldova, Mongolia, Morocco, Mozambique, Myanmar, Nauru, Nepal, Nicaragua, Niger, Nigeria, Northern Mariana Islands, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Portugal, Qatar, Romania, Russian Federation, Rwanda, Sao Tome and Principe, Senegal, Senegal, Serbia, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Togo, Tunisia, Turkmenistan, Tuvalu, Tanzania, Uganda, Ukraine, Uruguay, Uzbekistan, Vanuatu, Venezuela, Viet Nam, Wallis and Futuna Islands, Yemen Zambia, Zimbabwe

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Tuberculosis Symptom Survey

Name: _____

Date of Birth: _____

Student L #: _____

Complete IF history of POSITIVE Tuberculin skin test or IGRA (T-spot or QFT).

Positive TB Test Date: _____ Induration: _____ **OR Positive IGRA** Date: _____

Enclose copy of positive TB test documentation

Last Chest X-Ray Date: _____ Result: _____

(Enclose a copy of the most recent chest x-ray report)

Have you taken medication for TB infection: Yes: □ No: □ **If Yes**, Medication: _____

Date Began: _____

Date Completed: _____

□ INH □ Rifampin □ 3HTP

Do you currently have any of the following symptoms?

1. Cough lasting more than three weeks? Yes □ No □
2. Unexplained weight loss? Yes □ No □
3. Loss of appetite? Yes □ No □
4. Unexplained fatigue? Yes □ No □
5. Fever and night sweats? Yes □ No □
6. Blood tinged sputum production? Yes □ No □

If "Yes" to any question, please explain further, including date of onset and any treatment.

_____

I am aware that the six symptoms listed above are possible signs/symptoms of active TB that I should promptly report to my healthcare provider.

Student Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____ Phone: _____

LONGWOOD UNIVERSITY

Longwood University Health Center

106 Midtown Ave.

Farmville, Va. 23901

Phone : 434-395-2102 Fax: 434-395-2783

Name: _____

Date of Birth: _____

Student L #: _____

Meningococcal Vaccine Waiver

I have read and reviewed information on the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease and I choose not to be vaccinated against meningococcal disease.

_____

Signature of Student or Parent/Legal Guardian **Date**

Religious Exemption

Any student who objects on the grounds that administration of immunizing agents conflicts with his or her 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. A notarized certificate from your state health department must be attached.

Hepatitis B Vaccine Waiver

I have read and reviewed information on the risk associated with hepatitis B disease, availability and effectiveness of any vaccine against hepatitis B disease and I choose not to be vaccinated against hepatitis B disease.

_____

Signature of Student or Parent/Legal Guardian **Date**

Medical Exemption

As specified in the Code of Virginia 22.1-27.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):_____

DTP/DTaP/Tdap;DT/TD;OPV/IPV;HIB;Pneum;Measles;Rubella;Mumps;HBV;Varicella;Meningococcal. This contraindication is permanent ( ) or temporary ( ) and expected to preclude immunizations until:

Date (Mo/Day/Yr): _____

Medical Provider Signature: _____

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Waiver Information for Meningococcal Disease & Hepatitis B

Please read the following information on Meningococcal Disease and Hepatitis B before signing the waiver on the Certification of Immunization.

Hepatitis B

Hepatitis B is a potentially fatal disease that attacks the liver. The virus can cause short-term (acute) illness that leads to loss of appetite, tiredness, diarrhea and vomiting, jaundice (yellow skin or eyes) and pain in muscles, joints and stomach. Many people have no symptoms with the illness. It can also cause long-term (chronic illness that leads to liver damage, liver cancer, and death.

According to the Centers for Disease Control, about 800,000-1.4 million people in the U.S. have chronic Hepatitis B infection. Each year approximately 40,000 people, mostly young adults, become infected with Hepatitis B virus. Young adults are more likely to contract Hepatitis B infection due to greater likelihood of high-rick behaviors such as multiple sexual partners.

Approximately 3,000 people die from chronic Hepatitis B infection annually. It is spread through contact with blood and body fluids of an infected person, such as having unprotected sex with an infected person or sharing needles when injecting illegal drugs. Unvaccinated health-science students are at risk of contracting Hepatitis B through an accidental occupational needle stick exposure.

There are several ways to prevent Hepatitis B infections including avoiding risky behavior, screening pregnant women and vaccination. Vaccine is the best prevention. The vaccine series typically consists of three injections given over a six month period, which are available through your private health care provider or Local Health Department.

Meningococcal Disease

Meningococcal disease is the leading cause of bacterial meningitis in children 2-18 years old in the U.S. Meningitis is an infection of the brain and spinal cord coverings. Meningococcal disease can also cause blood infections. According to the Centers for Disease Control, about 2,600 people get meningococcal disease each year in the U.S. Of these cases, 10-15% die and of those who live, another 10% may require limb amputation, develop kidney failure or brain damage, become deaf, and suffer seizures or strokes.

College freshmen, particularly those who live in dormitories, have a slightly increased risk of getting meningococcal disease as illustrated by a case rate of 1.4/100,000 18-23 years old as opposed to a case rate of 1.4/1000,000 18-23 year olds in the general population.

Meningococcal vaccine is effective in preventing four types of meningococcal disease including two of the three most commonly occurring types in the U.S. The vaccine is 85-100% effective in preventing serotype A and C in older children and adults. It does not however protect against serotype B which causes one third of cases in patients 15-24 years. Therefore, in the event of an outbreak, even previously immunized individuals should contact their health care providers.

ACIP recommends routine vaccination of persons with meningococcal conjugate at age 11 or 12 years with a booster dose at age 16. **Persons who receive their first meningococcal conjugate vaccine at or after 16 years do not need a booster dose.** Routine vaccination of healthy persons 21 years or older who are not at increased risk of exposure to N. Meningitides is not recommended.

The vaccine is available at a Local Health Dept. or physician.