



To ensure the confidentiality of your medical information, mail the completed Health History Record to this address ==>>>

Student Health Center
Special Programs Building
28 Westhampton Way
University of Richmond, Virginia 23173
Phone (804) 289-8064

Email: Administrative: healthcenter@richmond.edu

Web Site: <http://healthcenter.richmond.edu>

Check-list for Undergrad Students and Parents

(This page is for you to keep.)

- Health History Records Due Date: July 15, 2009** (January 8, 2010 for Spring Admissions)
MAIL THE COMPLETED FORM IN ITS ENTIRETY TO THE HEALTH CENTER. *Faxes will not be accepted.*
 - Students not in compliance with ALL TB screening and immunization requirements for entrance to University of Richmond will have class registration and residence hall access blocked as of July 20 (January 15 for Spring Admissions) and may be subject to a \$100 fine.**
 - Do not use pencil to complete the Health History Record.**
 - Tuberculosis (TB) Risk Assessment (page 2) is required for ALL students.** After review of your TB Risk Assessment information by the Student Health Center staff, students identified as requiring further evaluation will be contacted by email with the necessary details before classes begin.
 - Immunizations:**
 - Required for ALL students:**
 - MMR (measles, mumps, rubella): 2 doses or equivalent individual doses of each
 - Tetanus booster (within past 10 years)
 - Polio Series
 - Hepatitis B: Completed series or signed waiver declining the vaccine
 - Meningococcal meningitis or signed waiver declining the vaccine
 - Recommended:**
 - Varicella (chickenpox)
 - Hepatitis A
 - Human Papilloma Virus
- Transfer students – Your previous institution may be a good source for immunization information. Have any records faxed directly to you to be given to your healthcare provider to complete your Health History Record.*
- Pre-college health examinations:** Have a comprehensive physical examination and necessary dental and eye examinations before coming to UR.
 - NCAA Athletes - Please sign and date top of page 4 (medical release). Do not send the Health History Record to the Training Room.** The Health Center will provide a copy of your Health History Record to the Training Room.
 - Disability Accommodation:** Complete application on [Office of Student Development](#) website.
 - Health Insurance:** Obtain adequate medical insurance and understand your coverage. This includes a policy providing coverage while living in Richmond for services such as emergency care, lab tests, and x-rays. Carry your insurance card and prescription drug card with you. Information on University-sponsored health coverage offered through [Raymond Jones & Assoc.](#) (804-730-1727) with Commercial Travelers Mutual Insurance Company.
 - Prescription Medication:** If you take prescription medications on a regular basis, you will need a plan to obtain them while living in Richmond. Understand your prescription drug insurance coverage before making arrangements with a local pharmacy. [Ukrops John Rolfe Pharmacy](#) will provide delivery of your medications to the Student Health Center.
 - Chronic Illness/Complex Medical Problem:** If you have a chronic illness or a complex medical problem requiring specialized treatment, please provide a medical summary from your physician with your diagnosis and treatment plan. If needed, the Student Health Center may assist you in arranging specialty care while in Richmond.
 - Allergy Shots:** The Student Health Center administers allergy shots. A prescribing allergist's detailed orders are required. If initiating allergy shot therapy, we require the first injection be given at the allergist's office.
 - Student Health Center:** Identify available health resources on campus and be familiar with off-campus resources available for after-hours emergencies. This information is on our web site at <http://healthcenter.richmond.edu>.
 - First aid supplies:** Recommended items to bring with you to campus: digital thermometer, acetaminophen, ibuprofen, cold medications, band-aids, topical antibacterial cream, a chemical cold pack and sunscreen.
 - If you would like to be notified your Health History Record has been received and is complete, please send an email to healthcenter@richmond.edu. You will be notified via email if your form is incomplete.**

WRITE YOUR NAME ON EVERY PAGE YOU SUBMIT.



Student Health Center
 Special Programs Building
 28 Westhampton Way
 University of Richmond, VA 23173
 Phone: 804-289-8064
 Email: healthcenter@richmond.edu
 Web: <http://healthcenter.richmond.edu>

FOR OFFICE USE ONLY:	Complete <input type="checkbox"/>
PPD <input type="checkbox"/> PPD Ex <input type="checkbox"/> Td <input type="checkbox"/> Polio <input type="checkbox"/> Hep B <input type="checkbox"/> Hep B Waiver <input type="checkbox"/>	
MMRs <input type="checkbox"/> <u>OR</u> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/>	
Men Vax <input type="checkbox"/> Men Waiver <input type="checkbox"/> Varicella Imm <input type="checkbox"/> Varicella not imm <input type="checkbox"/>	
Missing: _____	
Notified: _____	
Entered into Banner <input type="checkbox"/> If transfer, year of grad _____	

HEALTH HISTORY RECORD – 2009-2010

Deadline All Students: July 15, 2009 (Spring Semester Transfers - January 8, 2010)
 (Please keep a copy for your records)

**MAIL THE COMPLETED FORM *IN ITS ENTIRETY* TO THE HEALTH CENTER.
 FAXES WILL NOT BE ACCEPTED.**

Name _____ UR Student ID # _____
Last First Middle (UR ID# required)

Male Female Date of Birth ____/____/____ Social Security # _____
mo day year (SS# required for medical purposes)

Permanent Address _____
Street City State /Country Zip Code

Country of Birth _____ Email _____
(Please print clearly)

Phone _____ Cell _____

Please circle your incoming class status:

Undergrad 1st yr 2nd yr 3rd yr 4th yr

MEDICAL HISTORY

<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> ADD/ADHA</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies (annual/seasonal)</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma/Exercise-Induced Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Bone/Joint Disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Chickenpox</p> <p><input type="checkbox"/> <input type="checkbox"/> Circulatory Problems/Blood Clots</p> <p><input type="checkbox"/> <input type="checkbox"/> Convulsions/Seizures/Epilepsy</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Eating Disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental Health Disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> Gastrointestinal Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Gynecological Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis/Liver Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney/Urinary Problems</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Mononucleosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Elevated Cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Throat Infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Ear Infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Other – Explain Below</p>
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Remarks or Additional Information: _____

Allergies: medication/foods, etc (include reaction) _____

Significant illness/hospitalization/surgery (include dates): _____

History of psychiatric/psychological disorder (include dates): _____

Person to be notified in case of emergency: Name: _____

Address: _____ Phone Number: _____

Health Insurance Information: Obtain appropriate medical insurance. Carry your health insurance and prescription drug card with you.

REQUIRED INFORMATION - TO BE COMPLETED BY HEALTHCARE PROVIDER
(All information must be in English)

Full name: _____ Social Security # _____

To be completed by the student AND a licensed healthcare provider AFTER APRIL 1st OF THIS YEAR. This form will be returned if the healthcare provider is a family member. Any attached documents MUST BE in English and verified by the health care provider.

TB RISK ASSESSMENT

A. Tuberculosis (TB) Risk Assessment

1. Has the student ever had a **POSITIVE** TB skin test before?
 No If No, proceed to question 2.
 Yes If Yes, complete Tuberculosis Assessment Form, page 2b. Then proceed to page 3 (Immunization History).
2. Was the student born in a country listed in Appendix I (page 2a)?
 No If No, proceed to question 3.
 Yes **If Yes, the student's TB Risk Assessment must be done at the UR Student Health Center.** Do NOT have a TB skin test done now. Students will be contacted via email with the details of the mandatory TB Risk Assessment before classes begin. Proceed to page 3 (Immunization History).
3. Does the student have signs or symptoms of active TB disease?
 No If No, proceed to question 4.
 Yes If Yes, follow instructions in section B: Tuberculosis Testing (below). Then proceed to page 3 (Immunization History).
4. Using the criteria in Appendix II (page 2a), is the student a member of a high risk group?
 No If No, **STOP.** No tuberculin skin test required. Proceed to page 3 (Immunization History).
 Yes If Yes, follow instructions in section B: Tuberculosis Testing (below). Then proceed to page 3 (Immunization History).

B. Tuberculosis Testing

- If testing is indicated, perform either TB skin testing **OR** IGRA testing, as below.
- **NOTE:** Testing must be done in the U.S. after APRIL 1st of this year.
- Place tuberculin skin test **or** perform Interferon Gamma Release Assay (IGRA) testing **as directed below.**
- A history of BCG vaccination should not preclude testing.
- Chest x-ray is **NOT** an acceptable screening test in lieu of skin testing or IGRA testing.

For TB skin testing: Mantoux test acceptable only: 0.1ml of PPD tuberculin containing 5 tuberculin units, intradermally, inner forearm.

Date PPD placed: ___/___/___ Date PPD read: ___/___/___ Results in millimeters: _____ (**record only numeric value for results**)
(Record actual MM of induration, transverse diameter; if no induration, record "0")

Interpretation (see Appendix III page 2a): Negative If negative, proceed to page 3 (Immunization History)
 Positive If positive, complete Tuberculosis Assessment Form (page 2b). Then proceed to page 3 (Immunization History)

For Interferon Gamma Release Assay (IGRA):

Date of test ___/___/___ Specify method (circle one): GFT-G QFT-GIT Other _____

Results/Interpretation: Negative If negative, proceed to page 3 (Immunization History).
 Indeterminate If IGRA results are indeterminate, place TB skin test.
 Positive If positive, complete Tuberculosis Assessment Form (page 2b). Then proceed to page 3 (Immunization History)

The above information must be verified by a health care provider or public health official with full name, signature, title and complete address and phone number.

Signature of Health Care Provider: _____ Date: _____

Please print or stamp examiner's name: _____ Phone: _____

Address: _____ Fax: _____

Appendix I

Countries with TB incidence rate (>19 cases) per 100,000 population per World Health Organization Global TB Control, WHO Report 2006.

Afghanistan	Congo DR	Kenya	New Caledonia	Sri Lanka
Algeria	Cote d'Ivoire	Kiribati	Nicaragua	Sudan
Angola	Croatia	Korea-DPR	Niger	Suriname
Anguilla	Djibouti	Korea-Republic	Nigeria	Syrian Arab Republic
Argentina	Dominican Republic	Kuwait	Niue	Swaziland
Armenia	Ecuador	Kyrgyzstan	N. Mariana Islands	Tajikistan
Azerbaijan	Egypt	Lao PDR	Pakistan	Tanzania-UR
Bahamas	El Salvador	Latvia	Palau	Thailand
Bahrain	Equatorial Guinea	Lesotho	Panama	Timor-Leste
Bangladesh	Eritrea	Liberia	Papua New Guinea	Togo
Belarus	Estonia	Lithuania	Paraguay	Tokelau
Belize	Ethiopia	Macedonia-TFYR	Peru	Tonga
Benin	Fiji	Madagascar	Philippines	Tunisia
Bhutan	French Polynesia	Malawi	Poland	Turkey
Bolivia	Gabon	Malaysia	Portugal	Turkmenistan
Bosnia & Herzegovina	Gambia	Maldives	Qatar	Tuvalu
Botswana	Georgia	Mali	Romania	Uganda
Brazil	Ghana	Marshall Islands	Russian Federation	Ukraine
Brunei Darussalam	Guam	Mauritania	Rwanda	Uruguay
Bulgaria	Guatemala	Mauritius	St. Vincent & The Grenadines	Uzbekistan
Burkina Faso	Guinea	Mexico	Sao Tome & Principe	Vanuatu
Burundi	Guinea-Bissau	Micronesia	Saudi Arabia	Venezuela
Cambodia	Guyana	Moldova-Rep.	Senegal	Viet Nam
Cameroon	Haiti	Mongolia	Seychelles	Wallis & Futuna Islands
Cape Verde	Honduras	Montenegro	Sierra Leone	W. Bank & Gaza Strip
Central African Rep.	India	Morocco	Singapore	Yemen
Chad	Indonesia	Mozambique	Solomon Islands	Zambia
China	Iran	Myanmar	Somalia	Zimbabwe
Colombia	Iraq	Namibia	South Africa	
Comoros	Japan	Nauru	Spain	
Congo	Kazakhstan	Nepal		

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of >20 cases per 100,000 population. For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp

Appendix II:

Criteria to determine if student is a member of high-risk group:

Unexplained weight loss, night sweats, persistent cough > 3 weeks
 Cough with the production of bloody phlegm/sputum
 Close contact with a known case of active TB
 Cancer, diabetes, kidney disease
 Use of illegal injected drug
 HIV infection
 Lived or traveled greater than 1 month in any country in **Appendix I**.

Immunosuppressive therapy
 Healthcare worker or student entering a healthcare profession
 Employee or long-term volunteer of a nursing home, homeless shelter, or correctional facility
 Removal of part of your stomach
 Silicosis

Appendix III:

Interpretation Guidelines:

>5 mm is positive:

Recent close contact of an individual with infectious TB
 Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
 Organ transplant recipients
 Immuno-suppressed persons: taking >15 mg/d of prednisone for >1 month; taking a TNF~alpha-antagonist
 Persons with HIV/AIDS

>10 mm is positive:

Persons born in a high prevalence country or who resided in one for > 1 month
 History of illicit drug use
 Mycobacteriology laboratory personnel
 History of resident, worker, or volunteer in high-risk congregate settings
 Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck, or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

Persons with no known risk factors for TB disease

REQUIRED INFORMATION - TO BE COMPLETED BY HEALTHCARE PROVIDER
 (In accordance with Virginia state law, you must provide information about your immunization status for certain vaccinations. All information must be in English.)

Full name: _____ Social Security # _____

To be completed and signed by a licensed health care provider. This form will be returned if the healthcare provider is a family member. Any attached documents **MUST BE TRANSLATED** into English by the health care provider.

PLEASE NOTE: It is the student's responsibility to return the ORIGINAL, completed Health History Record by **July 15, 2009** for Fall Semester or **January 8, 2010** for Spring Semester. **MAIL THE COMPLETED FORM IN ITS ENTIRETY TO THE HEALTH CENTER.**
Faxes will not be accepted.

STUDENTS NOT IN COMPLIANCE WITH ALL OF THE TB SCREENING AND IMMUNIZATION REQUIREMENTS FOR ENTRANCE TO UR WILL HAVE CLASS REGISTRATION AND RESIDENCE HALL ACCESS BLOCKED AS OF JULY 20 (JANUARY 15 for Spring Admission) AND MAY BE SUBJECT TO \$100 FINE.

REQUIRED IMMUNIZATIONS	DATES ADMINISTERED	WAIVERS
Tetanus/Diphtheria Booster (required within past 10 years)		Hepatitis B Waiver I have read the information on the web site about Hepatitis B and the Hepatitis B vaccine. I have either not started or have not completed the series of vaccines. I understand the risks of the disease; however, I choose not to receive the vaccine but understand I must sign the waiver to complete my records. Student's Printed Name: _____ UR ID#: _____ Date of Birth: _____ Signature: _____ Today's Date: _____ <i>(Parent/guardian's signature required if student is under the age of 18)</i>
<input type="checkbox"/> Td _____ OR <input type="checkbox"/> Tdap _____ <div style="text-align: center;">M D Y</div>		
Polio		
Completed Primary Series? <input type="checkbox"/> No <input type="checkbox"/> Yes Date last dose given _____ <div style="text-align: center;">M D Y</div>		
Hepatitis B		
#1 _____ #2 _____ #3 _____ OR Complete Waiver → <div style="text-align: center;">M D Y M D Y M D Y</div> (Must sign waiver if series is not complete at time forms are submitted to UR.) Alternatives <input type="checkbox"/> 2-dose adolescent series <input type="checkbox"/> Twinrix		
Measles, mumps, and rubella (MMR) (after first birthday and if born after 1971)		
MMR #1 <u>after</u> first birthday _____ <div style="text-align: center;">M D Y</div> MMR #2 at least 30 days after MMR #1 _____ <div style="text-align: center;">M D Y</div>		

>>IF MEASLES, MUMPS, AND RUBELLA GIVEN AS INDIVIDUAL ANTIGENS – DOCUMENT ALL VACCINATIONS GIVEN

Measles (Rubeola) two doses vaccine required (after first birthday and 1967)	#1 _____ #2 _____ <div style="text-align: center;">M D Y M D Y</div>	OR Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)
Mumps two doses vaccine required (after first birthday and 1967)	#1 _____ #2 _____ <div style="text-align: center;">M D Y M D Y</div>	OR Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)
Rubella two doses vaccine required (after first birthday and 1969)	#1 _____ #2 _____ <div style="text-align: center;">M D Y M D Y</div>	OR Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)

Meningococcal Meningitis	Meningococcal Vaccine Waiver
<input type="checkbox"/> Menactra (conjugate) <i>acceptable if after 7-1-05</i> _____ <div style="text-align: center;">M D Y</div> OR	I have read the information on the web site about meningococcal meningitis. I have either not been vaccinated or choose not to be vaccinated. I understand that in the event of an outbreak, unvaccinated students will be at increased risk for contracting the illness. I understand the risks of the disease; however, I choose not to be vaccinated but understand I must sign the waiver to complete my records. Student's Printed Name: _____ UR ID#: _____ Date of Birth: _____ Signature: _____ Today's Date: _____
<input type="checkbox"/> Menomune (polysaccharide) <i>acceptable if after 7-1-07</i> _____ <div style="text-align: center;">M D Y</div> (Must sign waiver if not vaccinated at time forms are submitted to UR.)	
RECOMMENDED IMMUNIZATIONS	
Varicella (Chicken Pox) #1 _____ #2 _____ OR <input type="checkbox"/> Documented History of Disease <div style="text-align: center;">M D Y M D Y</div>	
Hepatitis A #1 _____ #2 _____ <div style="text-align: center;">M D Y M D Y</div>	
Human Papilloma Virus #1 _____ #2 _____ #3 _____ <div style="text-align: center;">M D Y M D Y M D Y</div>	

All immunization dates must be verified by a health care provider or public health official with full name, signature, title and complete address and phone number.

Signature of Health Care Provider: _____ Date: _____

Please print or stamp examiner's name: _____ Phone: _____

Address: _____ Fax: _____

PHYSICAL EXAMINATION RECORD
(To be completed by health care provider)

Full Name: _____

Social Security # _____

Required of NCAA athletes ONLY:

1. Sport: _____

2. Urine Screen: Urinalysis (dip) glucose _____ protein _____ blood _____

3. Blood Work: Hgb _____ Hct _____

4. Physical Exam: NCAA requirement to participate in your sport.

Please sign below to authorize the Health Center to provide a copy of your Health History Record to the Athletic Training Room.

Student Athlete's Signature _____ Date _____

Drug Allergies: _____

Physical Examination:

Vision: (Corrected) R 20/____ L 20/____ (Uncorrected) R 20/____ L 20/____

Height: _____ (inches) Weight: _____ (pounds) B/P: ____/____ Pulse: _____

- | | | |
|--------------------------|--------------------------|------------|
| Normal | Abnormal | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. HEENT |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Neck |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Lungs |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Heart |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Abdomen |

- | | | |
|--------------------------|--------------------------|--------------------|
| Normal | Abnormal | |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Genitourinary |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Musculoskeletal |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Neurological |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Skin |

Describe any abnormalities: _____

Medical/Psychological conditions: _____

Current Medications:

Name of Medication	Dosage	Indication

Dietary Requirements: _____

Recommendations for physical activity: Unrestricted Restricted

(Explain restrictions) _____

Other Pertinent Information: _____

This form will be returned if the healthcare provider is a family member.

Signature of Health Care Provider: _____ Date: _____

Please print or stamp examiner's name: _____ Phone: _____

Address: _____ Fax: _____