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 Law/Graduate Students and Parents

(This page is for you to keep.)

☐ **Health History Records Due Date: July 15, 2009 (Fall Admissions) January 8, 2010 (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:

- **Grad students will have class registration blocked as of July 20 (January 15 for Spring Admissions).**
- **Law students will have their network accounts locked on Tuesday of the first week of class.**

☐ **Students not in compliance with TB screening and immunization requirements for entrance to University of Richmond are subject to a $100 fine.**

☐ **Do not use pencil to complete the Health History Record. Faxes will not be accepted.**

☐ **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

Recommended:

- Meningococcal meningitis
- Varicella (chickenpox)
- Hepatitis A
- Human Papilloma Virus

PLEASE NOTE: *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.*

☐ **Health Examinations:** A physical examination and any necessary dental and eye examinations are recommended but not required for matriculation.

☐ **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 ☐
PPD ☐ PPD Ex ☐ Td ☐ Polio ☐ Hep B ☐ Hep B Waiver ☐
MMRs ☐ OR Measles ☐ Mumps ☐ Rubella ☐
Men Vax ☐ Men Waiver ☐ Varicella Imm ☐ Varicella not imm ☐
Missing: ____
Notified: ____
Entered into Banner ☐ If transfer, year of grad __________

LAW/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 one:

Law	Yr 1	Yr 2	Yr 3	
MBA Program	Yr 1	Yr 2		
MACC	Yr 1			

If you are a visiting student, will you be attending UR for:
☐ 1 semester ☐ 1 year

If you attended UR as an undergrad, please notify us by emailing the Health Center at healthcenter@richmond.edu.

MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	ADD/ADHA	☐	☐	Diabetes	☐	☐	Mononucleosis
☐	☐	Allergies (annual/seasonal)	☐	☐	Eating Disorders	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Mental Health Disorder	☐	☐	Tuberculosis
☐	☐	Asthma/Exercise-Induced Asthma	☐	☐	Gastrointestinal Problems	☐	☐	Sexually Transmitted Disease
☐	☐	Bone/Joint Disorder	☐	☐	Gynecological Problems	☐	☐	Elevated Cholesterol
☐	☐	Cancer	☐	☐	Frequent Headaches	☐	☐	High Blood Pressure
☐	☐	Chickenpox	☐	☐	Heart Disease	☐	☐	Frequent Throat Infections
☐	☐	Circulatory Problems/Blood Clots	☐	☐	Hepatitis/Liver Disease	☐	☐	Frequent Ear Infections
☐	☐	Convulsions/Seizures/Epilepsy	☐	☐	Kidney/Urinary Problems	☐	☐	Other – Explain Below

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.*

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

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 FOR STUDENTS WITH POSITIVE TB SKIN TESTS
(All information must be in English)

Full name:____ Social Security # _______________________

To be completed with student and signed by student AND a licensed health care provider. *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.*

TUBERCULOSIS ASSESSMENT: For Students with POSITIVE Tuberculin Skin Tests Only

Date of positive TB skin test: Date:___/___/___ (M D Y) Result:_______________ (**report result in millimeters**)

Date of most recent chest x-ray: Date:___/___/___ (M D Y) Result:_______________ **Enclose copy of report**

Have you previously completed a course of medicine for TB infection? ☐ Yes ☐ No

If **Yes**, approximate date you completed the medication ___/___/___ (M D Y)

What medicine was taken and for how long? ____

Are you currently taking medication for TB infection? ☐ Yes ☐ No

If **Yes**, name of the medication ____

When did you start the medication? ___/___/___ (M D Y)

Will you need help getting the medication at University of Richmond? ☐ Yes ☐ No

If **Yes**, how can we help you? ____

Do you currently have any of the following symptoms?

Cough lasting greater than two weeks ☐ Yes ☐ No
Unexplained weight loss ☐ Yes ☐ No
Loss of appetite ☐ Yes ☐ No
Night sweats ☐ Yes ☐ No
Cough with bloody phlegm/sputum ☐ Yes ☐ No

If you checked "Yes" for any of the above symptoms, please explain further, including date of onset and any treatment.

I am aware that the five symptoms listed above are possible signs/symptoms of active tuberculosis disease that I should report promptly to my health care provider.

Student's Signature ____ Today's Date ____________________

All 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: ________________________

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 in English and verified 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.

GRAD STUDENTS NOT IN COMPLIANCE WITH ALL OF THE TB SCREENING AND IMMUNIZATION REQUIREMENTS FOR ENTRANCE TO UR WILL HAVE CLASS REGISTRATION BLOCKED AS OF JULY 20 (January 15 for Spring Admission) AND ARE SUBJECT TO A $100 FINE.

LAW STUDENTS NOT IN COMPLIANCE WITH ALL OF THE TB SCREENING AND IMMUNIZATION REQUIREMENTS FOR ENTRANCE TO UR WILL HAVE THEIR NETWORK ACCOUNTS LOCKED ON TUESDAY OF THE FIRST WEEK OF CLASSES AND ARE SUBJECT TO A $100 FINE.

REQUIRED IMMUNIZATIONS — **DATES ADMINISTERED** — **WAIVER**

Tetanus/Diphtheria Booster *(required within past 10 years)*

☐ Td
OR ☐ Tdap ___/___/___ (M D Y)

Polio

Completed Primary Series? ☐ No ☐ Yes Date last dose given ___/___/___ (M D Y)

Hepatitis B

#1 ___/___/___ (M D Y) #2___/___/___ (M D Y) #3___/___/___ (M D Y) **OR Complete Waiver** →
(Must sign waiver if series is not complete at time forms are submitted to UR.)

Alternatives ☐ 2-dose adolescent series ☐ Twinrix

Measles, mumps, and rubella (MMR) *(after first birthday and if born after 1971)*

MMR #1 *after* first birthday ___/___/___ (M D Y)

MMR #2 at least 30 days after MMR #1 ___/___/___ (M D Y)

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:_______________________________________

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

Vaccine	#1	#2	OR
Measles (Rubeola) two doses vaccine ***required*** (after first birthday and 1967)	___/___/___ (M D Y)	___/___/___ (M D Y)	**OR** Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)
Mumps two doses vaccine ***required*** (after first birthday and 1967)	___/___/___ (M D Y)	___/___/___ (M D Y)	**OR** Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)
Rubella two doses vaccine ***required*** (after first birthday and 1969)	___/___/___ (M D Y)	___/___/___ (M D Y)	**OR** Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)

RECOMMENDED IMMUNIZATIONS

☐ **Menactra (conjugate)** *acceptable if after 7-1-05* ___/___/___ (M D Y)
OR
☐ **Menomune (polysaccharide)** *acceptable if after 7-1-07* ___/___/___ (M D Y)

Varicella (Chicken Pox)
#1 ___/___/___ (M D Y) #2___/___/___ (M D Y) **OR** ☐ Documented History of Disease

Hepatitis A
#1 ___/___/___ (M D Y) #2___/___/___ (M D Y)

Human Papilloma Virus
#1 ___/___/___ (M D Y) #2___/___/___ (M D Y) #3___/___/___ (M D Y)

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		Normal	Abnormal	
☐	☐	1. HEENT	☐	☐	6. Genitourinary
☐	☐	2. Neck	☐	☐	7. Musculoskeletal
☐	☐	3. Lungs	☐	☐	8. Neurological
☐	☐	4. Heart	☐	☐	9. Skin
☐	☐	5. Abdomen			

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: _______________________