Dear Roanoke College Student:

Congratulations on your acceptance and decision to attend Roanoke College. We at Health Services look forward to serving your needs and wish you the best of luck as you begin your education.

Every new full time, or transfer student entering the college is REQUIRED to properly complete and return this health record. The tuberculosis risk assessment form(page 3) and if indicated the tuberculin skin test (PPD) must be within twelve months prior to entrance to Roanoke College. The physical (page 2) must be within twelve months prior to entrance to Roanoke College. Please carefully read the list of required immunizations (page 2) to be sure that you have complied fully with state and college requirements. Athletes, please see athletics website under athletic training for additional forms that need to be completed and returned to their office for sports participation.

Commonwealth of Virginia Law (Code of Virginia, Section 23-7.5) requires that all full-time students submit an immunization history that has been signed by a health care provider who documents all required immunizations. **FAILURE TO SUBMIT COMPLETE HEALTH RECORD WITH DOCUMENTATION OF ALL REQUIRED IMMUNIZATIONS WILL DELAY REGISTRATION.**

In addition to the required immunizations, there are two recommended vaccines: Varicella (chickenpox) if you have not had the disease, and Gardasil, a vaccine for girls and women age 9-26 which offers protection against diseases caused by the human papilloma virus (HPV).

Students are exempt from the immunization requirements if a medical contraindication or religious belief prohibits immunization. A signed statement from a health care provider is required for exemption. This form is available on our website. Those born before 1957 are also exempt from the requirement for measles/mumps/rubella (MMR) vaccine.

Many services are provided to students at no cost. Expenses incurred for prescription medication, physicals, immunizations, allergy injections, in-house laboratory procedures, or off campus doctor visits, x-rays, laboratory procedures, emergency room visits, or hospitalizations are the student's responsibility. Parents and students are encouraged to review health insurance prior to arrival to ensure the policy provides adequate coverage while living in Salem, VA. Please remember to send a front and back copy of your insurance card with your completed health forms. A student without insurance should visit our website at www.roanoke.edu/health to review the plan available to Roanoke College students.

*International students are required to have health insurance. Please review the health insurance requirements letter located on MyRoanoke or www.roanoke.edu/health.

Health records should be returned to: Roanoke College Health Services, 221 College Lane, Salem, VA 24153. If you have any questions please contact us at (540) 375-2286, FAX (540) 375-2252 or e-mail monroe@roanoke.edu.

**HEALTH FORMS MUST BE RETURNED AT LEAST ONE MONTH PRIOR TO THE START OF SEMESTER.**
Medication dosage is required and must be dated within twelve months.

**If you are currently prescribed medication for ADD/ADHD a letter from your physician with documentation of diagnosis and medication dosage is required and must be dated within twelve months.**

Return completed health records to: Roanoke College Health Services, 221 College Lane, Salem, VA 24153.

Contact information: Phone (540) 375-2286--Fax (540)375-2252--Email monroe@roanoke.edu.
REQUIRED IMMUNIZATIONS

TETANUS BOOSTER/ TDAP PREFERRED (WITHIN THE LAST TEN YEARS) DATE________________________

MMR (Measles, Mumps, Rubella) Two doses required after 12 months of age: Date #1___________ # 2 ____________

OR ATTACH COPY OF POSITIVE TITER RESULTS

POLIO Series Date completed __________________________

HEPATITIS B Series of 3 doses #1 ___________ #2 ___________ #3 ______ or sign waiver if decision made NOT to receive vaccine.

Hepatitis B Waiver I understand the risks of the disease. However, I choose NOT to receive the vaccine. __________________________ __________________________ (Student Signature or (parent/legal guardian if under age 18) Date __________)

Meningococcal Vaccine Date ___________ or waiver must be signed if decision made NOT to receive vaccine.

Meningococcal Vaccine Waiver I understand the risks of this disease. However, I choose NOT to receive the vaccine. I understand that in the event of an outbreak, I will be at increased risk for contracting the illness. __________________________ __________________________ (Student Signature (parent/legal guardian if under age 18) Date __________)

RECOMMENDED IMMUNIZATIONS

VARICELLA (Chicken Pox) #1 ___________ 

History of disease □ YES □ NO

GARDASIL (HPV) #1 ___________ #2 ___________ #3 ______

List any other Immunizations and dates: (any not listed above, or for travel) __________________________

Physical Health Evaluation Exam within 12 months prior to entering Roanoke College

Note to the Healthcare Provider: Please review the student’s history and complete this physical form. The information supplied will be used as a background for providing health care. No information will be released without the students written consent.

Temp _____ P _____ R _____ BP ___________ Ht.(inches) _______ Wt (lbs) ________

Corrected Vision: Right 20/____ Left 20/______ Hearing: Right _____ Left _______

Tuberculosis Screening (see page 3) Risk factors present Yes _____ No _____ If Yes, PPD documentation required

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<th>Abnormal</th>
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<td>Breasts</td>
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<td>Femoral pulses</td>
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</table>

Can this student participate in intercollegiate sports? YES NO Restrictions?______________________________

Is the patient now under treatment for any medical or emotional conditions? Yes No

Does the student take any medications regularly? Yes No

Do you have any recommendations regarding the care of this student? Yes No

Comments: (Attach letter if necessary) ____________________________________________________________

Date: ________________________________

Health Care Provider’s Signature ________________________________________________

Print Health Care Provider’s Name ________________________________________________

Office Address, Phone & Fax # __________________________________________________________

Return completed form to:
Student Health Services
Roanoke College
221 College LN
Salem, VA 24153
Phone: 540-375-2286
Fax: 540-375-2252
ROANOKE COLLEGE STUDENT HEALTH SERVICES
TUBERCULOSIS RISK ASSESSMENT FORM

Student Name_______________________________________________  RC ID#_________________________  Date_________________

The United States Public Health Service and the Centers for Disease Control and Prevention recommend that tuberculosis skin testing (PPD) be performed on all individuals who may be at increased risk of tuberculosis. Please complete the following:

Have you ever had a positive PPD test result? Yes___ No___  *If NO, continue to Sections 1-5. If YES, submit a copy of a current chest X-ray result, which must be within 12 months of entrance date to Roanoke College. Did you receive INH treatment? Yes____ No____ If “YES” give dates of treatment_____________________________  ____________________.

*Place a check in the box in front of any section that applies to you. You are required to have a PPD if any section is checked. This can be given to you by your health care provider or by Student Health Services after arrival to campus.

☐ Section 1: Check if you have any of the following symptoms:
  • Unexplained fever for more than one (1) week
  • Unexplained weight loss
  • Night sweats
  • Persistent cough of unknown etiology for more than 3 weeks.
  • Productive cough with bloody sputum

☐ Section 2: Check if any of these situations apply to you:
  • Close contact with a known or suspected case of active tuberculosis
  • Use of illegal injected drugs
  • At risk of being infected with HIV (Human Immunodeficiency Virus)
  • Health care worker in a medium or high risk health care facility in the past 12 months
  • Volunteer, resident or employee in a congregate living setting (homeless shelter, nursing home, correctional facility).

☐ Section 3: Check if you have any of the following health condition risks for tuberculosis:
  • Leukemia, lymphoma
  • Cancers of the head or neck
  • Silicosis
  • Gastrectomy, jejun ileal bypass, or chronic malabsorptive conditions
  • Diabetes
  • Chronic renal failure or on dialysis
  • Solid organ transplant (kidney, heart)
  • HIV infection
  • Prolonged corticosteroid therapy or other immunosuppressive therapy: chemotherapy
  • On any TNF antagonist medication(such as Humira, Enbrel, or Remicade for rheumatoid arthritis or Crohn’s disease)
  • Underweight or malnourished

☐ Section 4: Check if you have lived in or traveled to any country in the following areas of the world for a duration of three (3) months or more within the past five years:
  • Africa
  • Asia
  • Central America, including Mexico
  • India and other Indian Subcontinent nations
  • South Africa (except Australia, New Zealand)
  • Eastern Europe
  • Middle East (except Jordan, Lebanon, UAE)
  • South America
  • Caribbean nations
  • Spain, Portugal

☐ Section 5: None of the items listed in sections 1-4 apply, PPD (TB Test) is not required.

Date TB skin test placed _________________  Date read____________________

Interpretation: Positive   Negative   Induration __________ mm (if none, write “0”)

Health Care Provider signature:___________________________________________________