Student Health Record

Students are required to have a completed student health record on file at Health Services prior to the beginning of classes. Compliance with this form is a Commonwealth of Virginia and Roanoke College policy for all first-year and transfer students living on or off campus. The following items are needed to fulfill this requirement:

- A physical examination completed after 8/01/12. Athletes or potential athlete’s exam must be after 5/01/13. Make an appointment with your family physician now. It may take up to 12 weeks to get an appointment.
- Documentation of required immunizations.
- Tuberculosis risk assessment form. If indicated, the tuberculin skin test (PPD) or interferon gamma release assay must be within the past 12 months.
- The emergency contact and personal health history information.

In addition to the required immunizations, these vaccines are recommended:

- Varicella (chickenpox) 2 doses, if no history of disease.
- Quadrivalent Human Papillomavirus (HPV) a 3 dose vaccine series.
- Hepatitis A given as a series of 2 doses

Parents and students are encouraged to review your health insurance plan prior to arrival to ensure your policy provides adequate coverage while at college. Students should carry a current health insurance card (including a prescription card) with them at all times.

Students without health insurance should review the health plan for Roanoke College students at www.roanoke.edu/health.

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

There is no charge for students to be seen in the health center. Students may, however, incur a charge for lab testing, certain procedures, immunizations, and special exams such as women’s health or sports physicals. These fees can be paid by cash, check, Maroon Card, VISA, MasterCard, Discover or American Express. Fees associated with off campus doctor visits, x-rays, emergency room visits, or hospitalizations are the student’s responsibility.

Please return the student health record using the enclosed envelope.

Questions?
Phone: 540-375-2286
Fax: 540-375-2252
Email: healthservices@roanoke.edu

Completed Health Forms may be turned in at your scheduled Spring into Maroon Day in June, or mailed in by August 1st
Roanoke College Student Health Record

Release of Information
When appropriate to ensure your health, well-being and academic success, the Health Center may, in particular circumstances, share some of the information on your health record with the appropriate college official, only if deemed necessary. Freshmen and/or transfer students participating in athletics will have some of the health information released to the Athletic Department. It is your responsibility to inform us if you do not wish to release any specific information.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

Student Signature __________________________ Date __________________________

College Entrance Year: Fall or Spring __________ Entrance Status: Freshman____ Transfer_____

Name________________________________________ Roanoke College ID____________________

Last __________________________________ First ___________________________________ Middle _______

Date of Birth________________________ Country of Birth__________________________ Gender: Male Female _______

Home Address ____________________________________________

Street________________________ City_________________________ State________________________ Zip Code________________________

Telephone (______) ___________ Student Cell Phone(______) ___________ RC EmailAddress_________________________@mail.roanoke.edu

Parent/Guardian Name(s)__________________________ Work /Cell Phone__________________________

In Case of Emergency Notify __________________________ Name and Relationship to Student __________________________ Telephone (including area code) __________________________

Family Physician__________________________ Name__________________________ Address________________________ Telephone (including area code) __________________________

Personal Health History
Do you have any medication allergies? Yes ______ No ______ (If Yes, Specify): __________________________

Do you have other allergies? (Food, Insects, etc.) Yes ______ No ______ (If Yes, Specify): __________________________ Do you carry an EPI-Pen for this allergy? Yes ______ No ______

List any significant illnesses/hospitalizations/surgeries (include dates): __________________________

List any mental health conditions (include dates): __________________________

Medications: List all medications taken orally or by injection on a regular or frequent basis. List dosage and frequency - include vitamins and over the counter medications. __________________________

**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 12 months.

Roanoke College Health Services
221 College Lane
Salem, VA 24153
Phone: 540-375-2286 Fax: 540-375-2252
Email: healthservices@roanoke.edu
REQUIRED IMMUNIZATIONS (MUST BE REVIEWED AND COMPLETED BY HEALTH CARE PROVIDER)

Tetanus / Tdap Booster (must be within the last 10 years): DATE________________________

M.M.R. (Measles, Mumps, Rubella - two doses required after 12 months of age): DATE #1___________ #2___________

OR ATTACH COPY OF POSITIVE TITER RESULTS

Polio: #1___________ #2___________ #3___________ #4___________

Hepatitis B (3 doses): #1___________ #2___________ #3___________ or signed 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 (parent/legal guardian if under age 18) Date

Meningococcal Quadrivalent (A,C,Y, W-135) Vaccine: #1___________ #2___________ (If initial dose is given after age 16, no booster required)

Meningococcal Vaccine Waiver: I understand the risk 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___________ #2___________ History of Disease: ☐ YES Date: _________ ☐ NO

Quadrivalent Human Papillomavirus: #1___________ #2___________ #3___________

Hepatitis A Vaccine #1___________ #2___________

Physical Health Evaluation Must be after 8/01/12 - Athletes/potential athletes must be after 5/01/13

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 student’s written consent.

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

Corrected Vision: Right 20/_______ Left 20/_______ Hearing: Right _______ Left _______

Tuberculosis Screening (see next page signature required)

<table>
<thead>
<tr>
<th>Skin</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lungs</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>Heart</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>Supine</td>
<td>Standing</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>Extremities</td>
<td></td>
</tr>
<tr>
<td>Back/Spine</td>
<td>Neurological</td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td>Femoral pulses</td>
<td></td>
</tr>
</tbody>
</table>

Can this student participate in intercollegiate sports? YES NO List any 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) _______________________________________________________________

Health Care Provider Signature ________________________________ Date ______________________________

Print Health Care Provider Name ____________________________ Office Address, Telephone & Fax Number ____________________________

Roanoke College Health Services
221 College Lane
Salem, VA 24153
Phone: 540-375-2286 Fax: 540-375-2252
Email: healthservices@roanoke.edu.
ROANOKE COLLEGE STUDENT HEALTH RECORDS
TUBERCULOSIS RISK ASSESSMENT FORM
(Health Care Provider’s Signature Required)

Student ___________________________ Roanoke College ID ___________________________ DOB ___________________________

The United States Public Health Service and the Centers for Disease Control and Prevention recommend that tuberculin skin testing (PPD) be performed on all individuals who may be at increased risk of tuberculosis. Please complete following questions including Sections 1-6.

Have you ever had a positive tuberculin skin test? Yes____ No____ If YES, submit a copy of chest X-ray result.

Did you receive INH treatment? Yes____ No____ Dates of treatment: __________________________

*Place a check in the box in front of any section(s) that applies to you. You are required to have a PPD or interferon gamma release assay if sections 1-4 are 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, jejunoileal 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 or traveled to any country in the following areas of the world for duration of three months or more within the past five years:

☐ Africa
☐ Asia
☐ Caribbean nations
☐ Central America (including Mexico)
☐ Eastern Europe
☐ India and other Indian Subcontinent nations
☐ Middle East (except Jordan, Lebanon, UAE)
☐ South Africa (except Australia, New Zealand)
☐ South America
☐ Portugal

Section 5:

☐ Section 1 – 4 does not apply to student. PPD (TB skin test) is not required:

Health Care Provider Signature: ___________________________ Date __________________________

Section 6:

☐ Section 1 – 4 applies to student. PPD (TB skin test) is required:

Date TB skin test placed _________ Date Read ________________

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

Health Care Provider Signature ___________________________ Date __________________________

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