

# University of Mary Washington

1301 College Avenue, Fredericksburg VA 22401  
Student Health Center – Lee Hall 112  
Phone 540-654-1040, FAX 540-654-1077  
www.students.umw.edu/healthcenter

# Health History

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Virginia State law (§ 23.1-800) requires that all full-time students enrolled for the first time in any baccalaureate public institution of higher education submit a health history. This form satisfies that requirement. The Student Health Center (SHC) does not require a physical examination but it does require a visit to your health provider for immunization records and verification with a signature. This document is an editable PDF, that is, for most information areas you may type on the form rather than handwrite.

Please keep a copy for your records and send the **ORIGINAL**, with signatures, to:

**University of Mary Washington  
Student Health Center  
1301 College Avenue  
Fredericksburg, VA 22401**

This form is due **AUGUST 1<sup>st</sup>** for the Fall Term  
or **JANUARY 3<sup>rd</sup>** for the Spring Term.  
If you fail to submit this form you will be unable  
to register for the following semester.

## General Information

Student Name: \_\_\_\_\_ Entering Semester/Year: \_\_\_\_\_  
Last First MI

What is your preferred name, that is, how do you wish to be addressed? \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ UMW email: \_\_\_\_\_

Gender Identity:  Man  Woman  Transgender  Self Identify: \_\_\_\_\_

Parent(s) or Guardian: \_\_\_\_\_

Full Home Address: \_\_\_\_\_  
number and street city state zip

Phone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Citizenship:  U.S.  Other: \_\_\_\_\_

Country of birth if not U.S.: \_\_\_\_\_ year entered US: \_\_\_\_\_

## Health Insurance

Do you have health insurance?  Yes  No If yes, which insurance? \_\_\_\_\_  HMO  PPO  POS

**Please attach a copy of your health insurance card.** While the SHC does not bill insurance, your card tells us where we can send you for lab and x-ray and who we can send you to for referrals. This also serves as a backup copy should you not be able to find yours in an emergency.

Please check to see if your insurance allows referrals in our area. Out-of-state students may find their medical insurance is not accepted in Virginia.

Kaiser insurance does not allow us to order lab or x-rays nor can we refer you to local providers. If you have Kaiser insurance you should go to the local Kaiser medical office for your care. It is located nearby at 1201 Hospital Drive, Fredericksburg VA 22401 (540) 368-3700.

Similarly, we cannot order lab or x-rays nor can we make referrals for Tricare Prime or other HMO patients.

## Emergency Contact Information – In the event of an emergency, I give the SHC permission to contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

## Minor Consent – Complete only if the student is under 18 years of age at time of enrollment.

The SHC needs written parental or legal guardian permission to provide medical care to minors.

*“I grant permission to the University of Mary Washington Health Center Physician and Staff to provide or secure medical treatment/care as needed for my son/daughter. In the event of a medical or surgical emergency I understand that every effort will be made to contact me prior to treatment, provided that doing so would not further jeopardize my child’s health or life.”*

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of Parent or Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**Health History**

Student Name: \_\_\_\_\_

**Family Medical History – Please explain any YES answers below.**

Any family members who died suddenly before the age of 50?  No  Yes \_\_\_\_\_

Any family members with blood clots?  No  Yes \_\_\_\_\_

Father:  Good health  No, please explain \_\_\_\_\_

Mother:  Good health  No, please explain \_\_\_\_\_

Brothers:  Good health  No, please explain \_\_\_\_\_

Sisters:  Good health  No, please explain \_\_\_\_\_

**Personal Medical History – Please answer all questions and explain any yes answers below.**

Do you have or have you had any ...

**Medical problems?**  No  Yes \_\_\_\_\_

**Mental health issues?**  No  Yes \_\_\_\_\_

Drug **allergies** or **intolerance?**  No  Yes \_\_\_\_\_

Any other **allergies?**  No  Yes \_\_\_\_\_

Any **serious injuries** or **concussions?**  No  Yes \_\_\_\_\_

Do you wear **glasses** or **contacts?**  No  Yes \_\_\_\_\_

Have you ever had **surgery?**  No  Yes \_\_\_\_\_

Have you ever been a patient in the **hospital?**  No  Yes \_\_\_\_\_

Do you have any **disabilities?**  No  Yes \_\_\_\_\_

Have you ever had **mononucleosis?**  No  Yes \_\_\_\_\_

Do you see any **specialists?**  No  Yes \_\_\_\_\_

Do you have any **diet** restrictions?  No  Yes \_\_\_\_\_

Do you take any **supplements?**  No  Yes \_\_\_\_\_

Do you take any **medications?**  No  Yes \_\_\_\_\_

Is there anything else we should know?  No  Yes \_\_\_\_\_

**Check List – Before submitting this form please check for the following:**

- Have your health provider review and sign your immunization and tuberculosis forms.
- Complete your health history and mail all original forms to us with a copy of your insurance card.
- Keep a copy of all forms for your records, in particular the immunization record.
- Put your insurance card in your wallet.
- If applicable, have a parent or guardian sign the minor consent form.

We understand that it is not always possible to go to your health provider before the forms are due and we don't want to make this a burden for you or us. You may submit an official electronic medical record printout of your immunizations for us to review. You may also come to the SHC when you arrive on campus and our nurses will be happy to review your forms, immunizations and tuberculosis screening and guide you through the process. Please don't ignore these forms. They are required by state law and you will be blocked from second semester registration if they are not completed.

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**UMW Immunization Record**

Page 1

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

All full-time students are required by the Code of Virginia (Section 23.1-800) to provide documentation of their immunizations by a health care professional (MD, DO, NP, PA or RN). Alternatively, you may submit an electronic medical record printout or other official copy of your immunizations. If you are unable to provide documentation, then vaccines may be repeated. If you are a foreign student, the documentation needs to be translated into English.

**Required Vaccinations – You will not be allowed to enroll without documentation.**

- Tetanus Diphtheria**       TD or  Tdap within the past ten years      Date: \_\_\_\_\_
- Mumps, Measles and Rubella**       MMR - 2 doses required **on or after first birthday** and at least 28 days apart  
Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_  
or  attach lab results confirming immunity
- Polio (OPV/IPV)**       Polio – At least three doses with **last dose given after age 4**  
Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_ Date 3: \_\_\_\_\_ Date 4: \_\_\_\_\_  
or  attach lab results confirming immunity  
If an adult booster was given after age 18      Date 5: \_\_\_\_\_

**Highly Recommended Vaccinations – You must provide vaccination dates or sign a waiver.**

- Hepatitis B**       3 doses  
Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_ Date 3: \_\_\_\_\_  
or  attach a copy of your lab results confirming immunity  
or  sign this waiver after reading the attached information about Hepatitis B vaccination.  
I have reviewed the information on the second page of this form 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      Date

- Meningitis (ACWY)**       Meningococcal Quadrivalent – Vaccine given **on or after 16th birthday**      Date: \_\_\_\_\_  
(Menactra, Menveo, or Menomune)      OR       sign this waiver after reading the attached information about meningitis vaccination.  
I have reviewed the information on the second page of this form on the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease, and I choose not to be vaccinated.  
\_\_\_\_\_  
Signature      Date

**Recommended Vaccinations – We recommend these vaccinations but they are not required.**

- Hepatitis A**       2 doses      Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_
- HPV (Genital wart vaccine)**       3 doses      Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_ Date 3: \_\_\_\_\_
- Varicella (Chicken pox)**       2 doses      Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_  
or  attach a copy of your lab results confirming immunity or  date of the disease: \_\_\_\_\_
- Meningitis B**      Bexsero or       2 doses      Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_  
Trumenba       3 doses      Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_ Date 3: \_\_\_\_\_

**Your health care provider must sign here to verify review of your vaccinations.**

\_\_\_\_\_  
Signature of Health Care Provider      Date      (\_\_\_\_\_) Phone Number

**Medical Exemption**

As specified in Section 22.1-271.2C(II) of the code, I certify that administration of the vaccines designated above would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because \_\_\_\_\_

This contraindication is  permanent (or)  temporary and expected to preclude immunization until \_\_\_\_\_

<b>Your health care provider must sign here to verify this medical Exemption.</b>		
_____	_____	(_____) _____
Signature of Health Care Provider	Date	Phone Number

**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. An affidavit of religious exemption must be submitted on a Certificate of Religious Exemption (Form CRE-1) which may be obtained at any local health department, school division superintendent's office, or local department of social services, or you may obtain a VA religious Exemption Form from [http://www.vdh.state.va.us/epidemiology/immunization/documents/cre\\_1.pdf](http://www.vdh.state.va.us/epidemiology/immunization/documents/cre_1.pdf).

**Hepatitis B**

Hepatitis B is a potentially fatal viral liver infection spread from person to person by contact with blood and body fluids. Most commonly this is through unprotected sex or by sharing infected needles when using illegal drugs. Hepatitis B may cause an acute, short-term illness with loss of appetite, fatigue, vomiting, diarrhea, muscle and joint aches, and jaundice (your skin and the whites of your eyes turn yellow).

Most people recover uneventfully and have no further problem with the virus. Others though may develop a chronic problem with liver damage, liver cancer, and death. The Centers for Disease Control reports that 1.25 million people in the United States have the chronic form of Hepatitis B with 80,000 people developing new cases each year. You are more likely to get Hepatitis B if you engage in high risk behaviors such as having multiple sexual partners or injecting illegal drugs.

About 4,000 people die each year from chronic Hepatitis B infection. You may prevent infection by avoiding risky behaviors and/or by vaccination. We believe that vaccination is the best prevention for everyone and recommend that you have three injections of Hepatitis B vaccine over a six-month period. The vaccine is highly effective and has few side effects ... typically some soreness at the injection site.

Most primary and secondary school systems require vaccination for school attendance. The State of Virginia mandates that you either have the vaccinations for college attendance or sign a waiver that you are aware of the risks and prefer not to be vaccinated.

You may receive the vaccine through your private health care provider, health department, or at the UMW Student Health Center.

**To register for classes you must have documentation of vaccination or sign the waiver on the other side of this form.**

**Meningococcal Meningitis**

Meningococcal disease is the major cause of bacterial meningitis in children 2-18 years old in the United States. Meningitis is an infection of the brain and spinal cord that can spread throughout the body. The Centers for Disease Control reports approximately 2,600 cases of meningococcal disease each year. If you get meningococcal disease, you have a 10 to 15% chance that you will die from it and another 10% chance that you will lose an arm or a leg, develop kidney failure, brain damage, deafness, seizures, or a stroke.

The risk of meningococcal disease is slightly higher in college freshmen living in dormitories with a risk of 5.4 cases for every 100,000 students. Though the risk is small, the consequences can be severe.

Meningococcal vaccine is 85 to 100% effective in preventing meningococcal disease for serotypes A and C. It does not protect against serotype B, which can cause one third of cases. Thus, the vaccine is effective in preventing many but not all cases of meningococcal disease. Should there be an outbreak of meningitis on the UMW campus, you should contact your health care provider whether you had the vaccine or not. Your risk of getting the disease yourself will be much lower if you have received the vaccine.

You may receive the vaccine through your private health care provider, health department, or at the UMW Student Health Center.

**To register for classes you must have documentation of vaccination or sign the waiver on the other side of this form.**

Student Name:

**Tuberculosis Screening**

Based on the guidelines published by the *American College Health Association*, the recommendations from the *Centers for Disease Control (CDC)* and the *American Thoracic Society*, tuberculosis screening is required within six months of college entry primarily by conducting a **Risk Assessment**. For more information, visit [www.acha.org](http://www.acha.org) or refer to the CDC's *Core Curriculum on Tuberculosis*

If a student is at low risk for tuberculosis, a PPD is not required for entrance into college.

**Question 1** Have you ever had a positive PPD?  Yes  No

If NO ..... Proceed to Question 2.

If YES ..... You must have a chest x-ray and submit the results.

**Question 2** Does the student have SIGNS or SYMPTOMS of ACTIVE TB DISEASE?  Yes  No

(Fever, night sweats, chills, fatigue, unintended weight loss, loss of appetite, pain with breathing or coughing)

If NO ..... proceed to Question 3.

If YES ..... proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

**Question 3** Is the student a member of a HIGH RISK GROUP?  Yes  No

Students are in a high risk group if they have HIV ... or they inject illegal drugs ... or they have resided in, volunteered in or worked in high risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters ... or they have diabetes, chronic renal failure, leukemias, lymphomas, low body weight, gastrectomy and jejunioleal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone >= 15 mg/day for >= one month), or other immunosuppressive disorders.

If NO ..... proceed to Question 4.

If YES ..... place tuberculin skin test (Mantoux only, inject 0.1 ml of purified Protein Derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm. If PPD is not placed, a T-spot, QFT-G or chest x-ray is required.

**Question 4**

Has the student LIVED or TRAVELLED (spent six weeks or more) in countries where TB is endemic?  Yes  No

Includes those students who have arrived within the past 5 years from countries OTHER than those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

If NO to #1, #2, #3 and #4 neither a PPD nor a chest-ray is required. Please sign below.

If YES ..... Students should undergo tuberculin skin testing, blood testing and/or chest x-ray.

**Please document testing and sign here.**

A. Tuberculin Skin Test Date given: \_\_\_\_\_ Date read: \_\_\_\_\_

Result: \_\_\_\_\_ mm (record actual millimeters of induration, not redness. If no induration write "0")

Interpretation (based on mm of induration as well as risk factors)  Positive  Negative

B. Interferon-Gamma Release Assay Date: \_\_\_\_\_ T-spot  Positive  Negative QFT-G  Positive  Negative

C. Chest X-ray (required if TB skin test is positive or if PPD has not been placed but patient is at risk of disease)

Results:  Normal  Abnormal Date of Chest x-ray \_\_\_\_\_

INH initiated Date \_\_\_\_\_ x \_\_\_\_\_ months

**Your health care provider must sign here to verify tuberculosis screening.**  
\_\_\_\_\_  
Signature of Health Care Provider Date (\_\_\_\_\_) Phone Number