Required Health Records for all Students

Failure to complete all required forms and immunizations can prohibit you from registering for classes

Health Records are due SEPTEMBER 1 for Fall Students and FEBRUARY 1 for Spring Students
HEALTH FORMS – CHECKOFF SHEET

Below is a checklist to help you in organizing your required Health Record documentation.

All students are required to submit the following documentation:

- Report of Medical History Form (completed by student)
- Physical Exam Form (MUST BE on form AND signed by Physician, Physician Assistant, or Nurse Practitioner). Must be current – within 12 months of beginning class.
- Immunization Record Form (MUST BE on form AND signed by Physician, Physician Assistant, or Nurse Practitioner)
  - Tdap or tetanus booster – within the last 10 years
  - MMR (measles, mumps, rubella) – 2 dose series or titer showing immunity
  - Tuberculosis – Quantiferon Gold blood test, T-Spot blood test, or PPD test are required annually (must include date given, date read, and results).
  - Polio – verified case, record of childhood vaccination (strongly preferred), titer, or physician’s note stating the following: “Patient is not a candidate for a booster at this time.”
  - Hep B – 3 dose series or titer showing immunity
  - Chicken Pox – verified case, 2 dose series, or titer showing immunity (required for PA students; must also have documentation)
  - Meningitis – Required for all Students
  - Influenza – Required for all Clinical Students; Recommended for all students each season (October – March)
- Continued Responsibility Statement (signed by student)
- Emergency Contact (completed by student)
- Health Insurance (submit copy of front and back of ID card)
  - Recommended for all students
  - Required for ALL students entering a CLINICAL semester.
- Medical Consent Form for Minors (signed by student if under 18 years of age)

STUDENTS ARE ENCOURAGED TO MAINTAIN COPIES OF ALL DOCUMENTS SUBMITTED AS IMMUNIZATION RECORDS MAY BE REQUIRED FOR EMPLOYMENT AFTER GRADUATION.
REPORT OF PERSONAL MEDICAL HISTORY

(check if you have had any of the following)

❑ Anemia ❑ Frequent Cough ❑ Night Sweating
❑ Arthritis ❑ Glasses/Contact Lens ❑ Recent Weight Gain or Loss/how many _____ lbs.
❑ Asthma ❑ Head Injury/Concussion ❑ Rheumatic Fever
❑ Alcohol Abuse ❑ Hearing Aid(s) ❑ Sinusitis
❑ Back Problem ❑ Heart Problem/Murmur ❑ Skin Disorder
❑ Cancer ❑ Hepatitis ❑ Substance Abuse
❑ Chronic Fatigue ❑ High Blood Pressure ❑ Tonsillitis (Chronic)
❑ Convulsion ❑ Infectious Mononucleosis ❑ Tuberculosis
❑ Diabetes ❑ Kidney Problems ❑ Ulcer
❑ Eating Disorder ❑ Lyme Disease ❑ Unexplained Aches & Pains
❑ Emphysema ❑ Malaria ❑ Use Smokeless/Chewing tobacco
❑ Epilepsy ❑ Meningitis ❑ Smoke Cigarettes, Cigars, or Pipe
❑ Fainting Spells ❑ Migraine/Frequent Severe Headaches How many years _____
❑ Muscle Disorder ❑ Headaches How many a day _____

Other medical or psychological conditions that you believe we should be aware of? (Please explain)
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
List any allergies _____________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Have you ever been hospitalized? Had any operations? (Please note details) __________________________
____________________________________________________________________________________
____________________________________________________________________________________
List all current medications _____________________________________________________________
List any serious injury _________________________________________________________________

FAMILY HISTORY

<table>
<thead>
<tr>
<th></th>
<th>AGE</th>
<th>STATE OF HEALTH</th>
<th>OCCUPATION</th>
<th>AGE OF DEATH</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has any of your immediate family ever had any of the following? (Please state relationship)
❑ Cancer ______________________________
❑ Diabetes ____________________________
❑ Heart Disease ________________________
❑ High Blood Pressure __________________
❑ Kidney Problems ______________________
❑ Tuberculosis _________________________
❑ Other ________________________________

I hereby certify that the information submitted on this record is complete and correct.

Student Name – Printed LEGIBLY                  Date

Student Signature                  Date
A physical examination is required and must be completed and signed by appropriate personnel. It must be current – within 12 months of starting classes.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth (month/day/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Permanent Address**

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Weight (pounds)</th>
<th>Area Code/Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IF REQUIRED:**

<table>
<thead>
<tr>
<th>Semester of Entry</th>
<th>Fall</th>
<th>Spring</th>
<th>Summer</th>
<th>Yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Program of Study:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Vision:**

<table>
<thead>
<tr>
<th>Corrected</th>
<th>Right 20/</th>
<th>Left 20/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncorrected</td>
<td>Right 20/</td>
<td>Left 20/</td>
</tr>
</tbody>
</table>

**Hearing:**

<table>
<thead>
<tr>
<th>(gross)</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 ft.</td>
<td>Right</td>
<td>Left</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are there abnormalities?

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>DESCRIPTION (attach additional sheets if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Head, Ears, Nose, Throat

2. Eyes

3. Respiratory

4. Cardiovascular

5. Gastrointestinal

6. Hernia

7. Genitourinary

8. Musculoskeletal

9. Metabolic/Endocrine

10. Neuropsychiatric

11. Skin

12. Mammary

A. Is there loss or seriously impaired function of any paired organs? Yes ___ No ___

Explain ________________________________________________________________

B. Is student under treatment for any medical or emotional condition? Yes ___ No ___

Explain ________________________________________________________________

C. Recommendation for physical activity (clinical experiences, intramurals, etc.) Unlimited ___ Limited ___

Explain ________________________________________________________________

D. Is student physically and emotionally healthy? Yes ___ No ___

Explain ________________________________________________________________

E. Other medical or psychological conditions that you believe we should be aware of?

_____________________________________________________________________

Based on my assessment of this student’s physical and emotional health on _____________, he/she appears able to participate in the activities of a health profession in a clinical setting. (Date) Yes ___ No ___

If no, please explain ________________________________________________________________

Signature of Healthcare Professional (MD, PA, NP, Nurse, etc.) __________________________

Print name of Healthcare Professional (MD, PA, NP, Nurse, etc.) __________________________

Office Address __________________________ City __________________ State __________________ Zip Code __________________________

Area Code/Phone Number __________________________
# STUDENT IMMUNIZATION RECORD

This form is mandatory and must be signed by a Healthcare Professional (MD, PA, NP, Nurse, etc.)

| Name: ________________________________________________________________________________ |
| Last | First | Middle |

<table>
<thead>
<tr>
<th>Tetanus/Diphtheria/Pertussis – Tdap required every 10 years</th>
<th>Tdap date ______________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Measles, Mumps, Rubella (MMR)</th>
<th>Required for all students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1 __________</td>
<td>or Titer Date ______________ (Attach Titer Copy)</td>
</tr>
<tr>
<td>Dose 2 __________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tuberculosis – Required annually for all students (IF PPD, 2-step required if no PPD in last 15 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculin Skin Test</td>
</tr>
<tr>
<td>1-step: Date Given: _______ Date Read _______ Negative □ Positive □</td>
</tr>
<tr>
<td>(attach documentation for previous PPD results)</td>
</tr>
<tr>
<td>2-step: 1st Date Given: ______ Date Read ______ Negative □ Positive □</td>
</tr>
<tr>
<td>2nd Date Given: ______ Date Read ______ Negative □ Positive □</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>QuantiFERON TB Gold Test</td>
</tr>
</tbody>
</table>

If PPD is positive, attach Chest X-Ray Report (Chest X-rays are good for 5 years.)

<table>
<thead>
<tr>
<th>Polio</th>
<th>Required for all students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1 __________</td>
<td>or Titer Date ______________ (Attach titer copy showing immunity)</td>
</tr>
<tr>
<td>Dose 2 __________</td>
<td>or Titer Date ______________ (Attach titer copy showing immunity)</td>
</tr>
<tr>
<td>Dose 3 __________</td>
<td>or Titer Date ______________ (Attach titer copy showing immunity)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hepatitis B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1 __________</td>
</tr>
<tr>
<td>Dose 2 __________</td>
</tr>
<tr>
<td>Dose 3 __________ Required for all students</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Varicella (Chicken Pox)</th>
<th>Required for all students; PA students require a Titer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1 __________ Verified Case Date __________ or Titer Date ______________ (Attach titer copy showing immunity)</td>
<td></td>
</tr>
<tr>
<td>Dose 2 __________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bacterial Meningitis – Required for resident students; recommended for all students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date __________ Exp Date __________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Influenza Vaccination – Required for all clinical students; Recommended for all students each season</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date __________ (attach documentation)</td>
</tr>
</tbody>
</table>

Healthcare Professional Name, Address, Phone Number and Signature (Required)

| Name: ____________________________ | Date: ____________________________ |
| Signature: ____________________________ | Phone: ____________________________ |
| Address: ____________________________ |  |
## Immunization Requirements

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tetanus-Diptheria</strong></td>
<td>Primary series with DTaP or DTP and booster with Td in the last ten years meets requirement.</td>
</tr>
</tbody>
</table>
| **Measles, Mumps, Rubella (MMR)** 2 doses required | Dose 1 – given at age 12-15 months or later  
Dose 2 – given at age 4-6 years or later, and at least one month after first dose. |
| **Tuberculosis**              | Quantiferon gold or T-spot blood test or PPD:  
Completed every 12 months – screening does not count – must have negative blood or scratch test.  
If scratch test is done (PPD) a 2-step PPD is REQUIRED if you have not had a PPD in the last 5 months.  
If you have had a PPD in the last 15 months, results from past PPDs must be submitted as well as the most recent PPD.  
If a student shows signs or symptoms of active tuberculosis disease you must proceed with additional evaluation to exclude active tuberculosis disease including tuberculin testing, chest X ray, and sputum evaluation.  
Negative chest x-rays are valid for 5 years. |
| **Polio – OPV alone Oral Sabin** 3 doses  
IPV/OPV sequential – 4 doses  
IPV alone injected Salk – 4 doses | Primary series in childhood meets requirements; three primary series schedules are acceptable. |
| **Hepatitis B**               | Three doses of vaccine or two doses of adult vaccine in adolescents 11 – 15 years of age or a positive Hepatitis antibody meets the requirement. |
| **Varicella**                 | Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after the age of 13 or older meets the requirement.  
History of Chicken Pox - A letter from the student’s parent listing history of chicken pox, dated and signed will meet the requirement. |
| **Bacterial Meningitis – 1 dose** | Required for all students |
| **Influenza – Each season**   | Required for all clinical students;  
Recommended for all students each season (October – March). |
CONTINUED RESPONSIBILITY STATEMENT

1) I understand that it is my responsibility to keep immunizations and TB skin tests current.

2) I agree to inform clinical instructors or the department head of any illness or health problem that could possibly affect my performance or the welfare of my patients in the clinical area.

3) I understand that if I am in a clinical rotation I am to have current health and accident insurance during each academic semester. I will maintain this coverage throughout the entire year.

4) I understand that I am to have a current CPR card in a clinical semester.

5) I attest that I have never been disbarred from and am not currently under investigation by a health (nursing/medicine, etc.) state licensure board.

6) I understand that I need to inform the College if I become aware that I am under investigation or if I am convicted of a criminal charge.

7) I understand that disclosure of the above is necessary to protect my health and the well-being of patients for whom I may provide care.

I have read the above and agree to act accordingly.

_________________________________
Student’s Printed (legible) Name

_________________________________
Student’s Signature

________________________
Date
EMERGENCY CONTACT INFORMATION
PLEASE PRINT CLEARLY

Student’s Printed Name ____________________________________________________________

Address: _____________________________________________

Street #            City      State      Zip

Phone: ___________________________        Cell Phone: ___________________________

Program of Study: _______________        Advisor: ___________________________

Physician’s Name/Phone Number: _____________________________________________

(Name)        (Phone Number)

Emergency Contact #1

Name: ___________________________        Relationship to Student _______________

Address: _____________________________________________

Street #            City      State      Zip

Phone #1: ___________________________        Phone #2 ___________________________

Please circle one: Home    Work    Cell

Please circle one: Home    Work    Cell

Emergency Contact #2

Name: ___________________________        Relationship to Student _______________

Address: _____________________________________________

Street #            City      State      Zip

Phone #1: ___________________________        Phone #2 ___________________________

Please circle one: Home    Work    Cell

Please circle one: Home    Work    Cell
HEALTH INSURANCE INFORMATION

All students are encouraged to have health insurance coverage.

Students in clinical semesters ARE REQUIRED to have health insurance coverage.

Students in clinical semesters who do not return this form prior to the beginning of their clinical semester WILL NOT be allowed to attend their clinical experience.

Medicaid coverage will be accepted with appropriate benefit card

Military IDs are accepted if you have military insurance

I understand that I am legally responsible for any medical expenses incurred during my enrollment and neither the College nor any clinical site will be responsible for my medical expenses.

Student’s Printed (legible) Name: ________________________________

Social Security Number: ________________

Insurance Company Name: __________________________________________

Policy Number: ______________________ Group Number: ________________

Subscriber Name: ________________________________________________

Signature: _______________________________ Date: ______________________

Student should sign if over 18 years of age.
Parents should sign if student is under 18 years of age.

ATTACH A COPY OF YOUR CURRENT INSURANCE CARD, FRONT, AND BACK TO THIS FORM.

Please attach a copy of the front of your insurance card here.

Please attach a copy of the back of your insurance card here.
Dear Parent or Legal Guardian:

The purpose of this consent form is to obtain permission from the parent or legal guardian for Radford University to seek treatment for a student who is under the age of 18 and therefore legally a minor.

Radford University has my permission to seek treatment for my child (print name of child legibly) ___________________________ in the event of a medical emergency. I understand that the College will make every effort to contact me before seeking this treatment if possible. I realize that Virginia State Law and professional codes of ethics may limit my access to confidential medical information regarding the treatment of my child.

________________________________________________________________________
Name of Student

_________________________________________ ____________________________
Name of Parent/Guardian (print) Relationship

_________________________________________ ____________________________
Signature Date

_________________________________________ ____________________________
Street Address Home Phone (please include area code)

_________________________________________ ____________________________
City, State, Zip Work Phone (please include area code)

________________________________________________________________________
Cell Phone (please include area code)