THE COLLEGE OF WILLIAM AND MARY
STUDENT HEALTH CENTER
P. O. Box 8795
Williamsburg, VA 23187-8795
Phone (757) 221-4386 / fax (757) 221-1245
E-mail: sthlth@wm.edu

Dear Student:

Congratulations on your acceptance to the College of William & Mary. We look forward to serving your health needs. To help us care for you, we need information about your health status. The Health Evaluation Form is comprised of 3 sections that are due July 1st for those students entering the fall semester and January 10th for those students entering the spring semester.

All full-time students, as well as any student eligible for services, are responsible for returning your health evaluation form to the Student Health Center (Code of Virginia 23-7.5). **This form will not be accepted if the physician completing and signing the form is a family member.**

Previously enrolled students, who are reentering as full-time students, after an absence from campus of greater than 2 years must update their health form to meet current standards. If the absence is greater than 6 years, the entire form requires resubmission.

For those seeking religious exemption, a Certificate of Religious Exemption (Form CRE-1) is the only form accepted.

Omission or misrepresentation of pertinent medical information is a violation of the honor system.

FAILURE TO COMPLETE THIS REQUIREMENT WILL RESULT IN A "HOLD" BEING APPLIED TO YOUR BANNER ACCOUNT AS WELL AS LATE FEES OF $100 ON AUGUST 31 FOR SUMMER/FALL ADMISSION OR ON FEBRUARY 28 FOR SPRING ADMISSION.

Sincerely,

Student Health Center Staff

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THIS FORM MUST BE SUBMITTED BY JULY 1 FOR FALL/SUMMER ADMISSION OR JANUARY 10 FOR SPRING ADMISSION OR YOU WILL BE CHARGED A LATE FEE OF $100

I. HEALTH HISTORY

To be completed by the Student.

Last Name	**First Name**	**Middle Name**	**Date of Birth**	**Student ID #**
Preferred Name	**Age**	**Place of Birth**	**Sex**	**Email Address**
Address	**City**	**State**	**Zip Code**	**Student Cell Phone**
Home Address (if different)	**City**	**State**	**Zip Code**	**Home Phone**
Emergency Contact	**Relationship**	**Home Phone**	**Cell Phone**	**Work Phone**

Date of Entrance: ☐ Fall ☐ Spring ☐ Summer 20 _____

☐ Undergrad. ☐ Grad ☐ Law ☐ VIMS ☐ Summer Student ONLY

If previously enrolled, last year attended: _____
Previous Name, if different than when you were last enrolled:
_____

Height _____ **Weight** _____

Any history of the following:	**Yes**	**No**
Asthma		
Migraine		
Cancer, Type_____		
Diabetes		
Epilepsy, Convulsions		
Heart Disease		
Kidney Conditions		
Please Circle - Depression/Anxiety		
Bipolar Disorder		
ADD/ADHD		
History of Eating Disorder		
Please Circle - Cutting/Self-Harm/Suicide Attempts		

Current Medications: _____
_____
_____
_____
_____

Any allergies to:	**Yes**	**No**
Medications Type & Reaction:		
Other allergies Type & Reaction:		

Any other significant conditions/treatments/disorders we should be aware of: _____
_____

If you answer Yes to the following questions please provide details in the space provided below.	**Yes**	**No**
Have you ever been treated for a psychological problem (disordered eating, depression, anxiety, etc.)?		
Have you been hospitalized or had any other illness or injury (other than those already listed)?		

Provide further detail for positive answers here: _____
_____
_____

NOTICE OF PRIVACY PRACTICES/PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
Information available on the College of William and Mary Student Health Ctr website at:
http://www.wm.edu/offices/healthcenter/documents/Patient-Notice-of-Privacy-Practices.pdf

PERMISSION FOR TREATMENT – If you are 18 or older, please sign form yourself: I grant permission to the Student Health Center physicians, Nurse Practitioners and Nurses to treat me for medical illnesses or preventative health care. Additionally, I authorize these same providers to hospitalize and/or secure treatment for me in the event of surgical, medical, or psychiatric emergency if I am unconscious or incompetent at the time.

Signature_____Date_____

If you are* under *18, a parent* or *guardian must also sign form:

Signature_____Relationship_____Date_____

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II. IMMUNIZATION RECORD

Must be completed & signed by a healthcare provider **OR** an official copy of your record must be attached (in English).

Last Name	First Name	Middle Name	Date of Birth	Student ID #

USE DATE FORMAT OF: MM/DD/YYYY

A. MMR (Measles, Mumps, Rubella) – REQUIRED - OR - attach Laboratory proof of immunity

Dose 1 given at age 12 months or later ____/____/____
Dose 2 given at least 28 days after first dose ____/____/____
OR as individual vaccines
Measles ____/____/____ Measles ____/____/____ Mumps ____/____/____ Mumps ____/____/____ Rubella ____/____/____
OR
Age exempt (born before 1957) for Measles/Mumps – Yes ☐ No ☐ (**Rubella is still REQUIRED**)

B. Hepatitis B – REQUIRED – OR – attach Laboratory proof of immunity – OR – sign waiver below – OR – Hepatitis B carrier (attach most recent lab reports)

Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ **OR**
Merck 2 dose adolescent series (ages 11-15) – Dose 1 ____/____/____ Dose 2 ____/____/____ **OR**

Waiver: I have reviewed the CDC website regarding Hepatitis B @ **http://www.cdc.gov/hepatitis/index.htm** and have been fully informed of the risks and health hazards of Hepatitis B infection as well as the benefits of the Hepatitis B vaccine. I choose not to be immunized against Hepatitis B infection at this time. Student signature (If you are under 18, parent or guardian must sign here):_____

C. Tetanus-Diphtheria - REQUIRED - OR- **PREFERRED Tdap – REQUIRED**

(Within 10 years) ____/____/____ (Within 10 years) ____/____/____

D. Meningococcal Tetravalent – REQUIRED – OR – Sign waiver below

All adolescents and teens ages 11-18 should be vaccinated, as should unvaccinated adults who are attending college.
A booster dose will be necessary for those who received their first dose before the age of 16.
Menactra ____/____/____ OR Menveo ____/____/____ OR Menomune (repeat every 3-5 years) ___/____/____

Waiver: I have reviewed the CDC website regarding Meningitis @ **http://www.cdc.gov/meningitis/index.html** and have been fully informed of the risks and health hazards of Meningitis infection as well as the benefits of the Meningitis vaccine. I choose not to be vaccinated against the Meningococcal disease at this time. Student signature (If you are under 18, parent or guardian must sign here):_____

E. Other vaccines NOT REQUIRED but are HIGHLY RECOMMENDED

Varicella Vaccine
Dose 1____/____/____ Dose 2 ____/____/____ - OR - History of Disease ____/____/____
Human Papillomavirus Vaccine (HPV)
Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____
Hepatitis A
Dose 1 ____/____/____ Dose 2 ____/____/____
Polio - Please specify IPV/OPV
Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ Dose 4 ____/____/____

Colleague: Thank you for taking time to assist us with this important task. We know that vaccine preventable diseases occur on college campuses where students are not immunized or inadequately immunized. You help us to protect all students and their contacts BY NOT ACCEPTING ANECDOTAL INFORMATION, and by submitting immunization data from your office records or from records presented for your review which include complete dates (month/day/year) of administration. Where records are missing or incomplete, updating immunizations helps to ensure that the student is protected, and enables him/her to complete requirements for matriculation at The College of William and Mary.

_____ **DATE THIS FORM WAS COMPLETED**

_____ **AN OFFICE STAMP MUST BE USED TO VALIDATE THIS FORM**

_____ **PRACTITIONER NAME/TITLE (M.D., N.P., R.N., P.A.)**

_____ **SIGNATURE**

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III. TUBERCULOSIS RISK ASSESSMENT

Last Name	First Name	Middle Name	Date of Birth	Student ID #

Yes	No	
		1. Do you have any of the following symptoms? Circle if applicable. Persistent cough — Unexplained fever for more than one week Coughing up blood — Loss of appetite Night sweats — Unexplained weight loss Chest pain
		2. Do any of these situations apply to you? History of positive PPD testing ** Close contact with someone diagnosed with or suspected of having tuberculosis Use of injected drugs At risk of being infected with HIV (Human Immunodeficiency Virus) Volunteer, reside, or an employee in a healthcare facility or congregate living setting (homeless shelter, nursing home, correctional facility)
		3. Do you have any of the following conditions that place you at increased risk for disease if infection occurs? Silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemia, lymphoma, or cancer of the head, neck, or lungs), gastrectomy or jejunoileal bypass, or weight loss of at least 10% below ideal body weight.
		4. Were you born in another country listed in Table 1 (next page) AND did you (or will you) arrive in the U.S. within the past 5 years? If so, list county _____
		5. Have you traveled within the last 5 years to one or more of the countries listed in Table 1 (next page) with a stay exceeding 4 weeks? If so, date of return _____ *If tested since your return, retesting is not indicated. Please document previous testing below.*

- **If you answered "No" to questions 1-5, TB Testing is NOT required (in this case, a physician's signature is not needed).**
- **If you answered "Yes" to ANY question above, TB Testing IS required.**

***Prior BCG Vaccine does NOT exempt one from this requirement (in this case, we recommend you have IGRA Testing).**

TB (PPD) Skin Test**	Chest X-Ray	Preventative Treatment
Date Administered: ____/____/____ Date Test Read: ____/____/____ Induration: ____ mm Result: Positive ☐ Negative ☐ **OR** – IGRA (ie: QFT-G or T spot) – **Recommended if prior BCG Vaccine given.** (Attach copy of written report.) Result: Positive ☐ Negative ☐	Required if skin test is positive Date of X-Ray: ____/____/____ Result: Positive Negative (Attach copy of written report.)	All students with a positive skin test or IGRA with no signs of active disease on chest X-Ray should receive a recommendation to be treated for latent TB with appropriate medication. Drug Prescribed: _____ Duration: _____ Patient Declined: _____

****If history of positive PPD, Chest X-Ray required and attach copy of written report.**

_____ _____
PRACTITIONER NAME/ TITLE(M.D., N.P., R.N., P.A.) **SIGNATURE**

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Table 1

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic Chad
China
Colombia
Comoros
Congo
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Korea (North/South)
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata.

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AIR CONDITIONER MEDICAL NECESSITY FORM

The Student Health Center physicians have been asked to screen all students requesting approval for air conditioners. The wiring system in some of the older residence halls is such that they can only handle a limited amount of additional load from air conditioners. For that reason, we need to **carefully** screen all air conditioner requests to ensure that those students who have true medical problems that would clearly be worsened without air conditioning are able to have air conditioners in their rooms. If you feel your patient meets these criteria, please provide the information below. Please understand the **final** decision will be made by one of our Health Center physicians. We appreciate your taking the time to provide this information so we can make the appropriate decision.

This form needs to be completed and returned by July 1st for those entering the Fall Semester and January 10th for those entering the Spring Semester.

You will not be approved for air conditioning until your Health Evaluation Form is complete.

Last Name	First Name	Middle Name	Date of Birth	Student ID #

Diagnosis: _____

Current Medicines being used to address the above diagnosis: _____

_____

_____

If Allergic Rhinitis is the diagnosis, please list (or enclose) results of skin testing, if done: _____

_____

Comments: _____

_____

_____

_____ _____

PRACTITIONER NAME/TITLE(M.D., N.P., R.N., P.A.) ***SIGNATURE**

PLEASE NOTE!

Students will not be approved for an air conditioner (if they meet the criteria) until the Student Health Center Staff is in receipt of their **COMPLETED** Health Evaluation Form.

Release of Information

I give my consent to allow a Release of Medical Information regarding the medical condition for which I am seeking an Air Conditioner or Special Housing to the Dean of Students and Residence Life at the College of William and Mary.

Signature_____Date_____

If you are* under *18, a parent* or *guardian must also sign form:

Signature_____Relationship_____Date_____

Student Health Center
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BEFORE MAILING FORM:

Please note: Your Student ID number can be found on your acceptance letter and is helpful in the processing of your Health Evaluation Form.

- ☐ Complete and sign Section I.
  (Parent/Legal Guardian **must** also sign for students under 18 years of age.)
- ☐ Examiner's signature is **required** to complete Sections II (unless official documentation provided) and III.
- ☐ All **required** immunizations must be **signed** by a practitioner or official documentation must be provided. (Be sure you have received your Meningitis Booster dose **after age 16** or signed the waiver.)
- ☐ Include all three sections (Sections I, II, III).
- ☐ Be sure your name and student ID number are on each page.
- ☐ Keep a copy of the form for your records.
- ☐ Are you interested in having an Advanced Medical Directive on file? If so, it can be found at:

  http://www.wm.edu/offices/wellness/healthcenter/documents/2012_VA_AMD_Simplifed___-Basic.pdf
- ☐ Include a copy of the front and back of your insurance card and your prescription insurance card (**unless** you have the College insurance plan). Please note: All students who do not wish to be enrolled in the College's Sponsered Student Health Insurance Plan are REQUIRED to complete the ONLINE insurance waiver **each year by August 31** (https://studentcenter.uhcsr.com/wm).

YOUR HEALTH EVALUATION FORM SHOULD BE SUBMITTED TO:
College of William & Mary
STUDENT HEALTH CENTER
P.O. Box 8795
Williamsburg, VA 23187-8795

ATHLETIC PARTICIPATION FORMS (IF REQUIRED) SHOULD BE SENT DIRECTLY TO THE ATHLETIC DEPARTMENT:
College of William & Mary
SPORTS MEDICINE
P.O. Box 399
Williamsburg, VA 23187-0399

Remember that all requested information is **required**. Incomplete health forms **cannot** be accepted. If you have any questions, please contact the Student Health Center at (757) 221-4386.
Mailing your form is preferred, but **legible** faxed forms are accepted; however, there is an **extremely high volume** of faxed forms the first few weeks of July. For this reason, it is more prudent to mail your form even though your form may arrive a bit late!

DO NOT FAX AND MAIL YOUR FORMS.