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

最后提交的扫描件不可遗漏此页。

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. 请全部用英文填写

Last Name	First Name	Middle Name	Date of Birth	Student ID #
姓	名	不填	格式：月/日/年	以930开头，在威玛寄来的邀请信上
Preferred Name	**Age**	**Place of Birth**	**Sex**	**Email Address**
	实际年龄	出生地	Male/Female	邮箱地址
Address	**City**	**State**	**Zip Code**	**Student Cell Phone**
学校统一地址：Beijing Normal University No. 19, XinJieKouWai St.	Beijing	China	100875	手机号
Home Address (if different)	**City**	**State**	**Zip Code**	**Home Phone**
	Beijing	China	100875	手机号
Emergency Contact	**Relationship**	**Home Phone**	**Cell Phone**	**Work Phone**
请填写父母一方				

Date of Entrance: ☐ Fall ☐ Spring ☑ Summer 20 17

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

If previously enrolled, last year attended: 一般没有
Previous Name, if different than when you were last enrolled: _____

Height 身高 _____ **Weight** 体重 _____

Any history of the following:	Yes	No
Asthma 气管炎		✔
Migraine 偏头痛		✔
Cancer, Type _____ 何种类型的癌症		✔
Diabetes 糖尿病		✔
Epilepsy, Convulsions 癫痫或抽搐		✔
Heart Disease 心脏疾病		✔
Kidney Conditions 肾脏情况		✔
Please Circle - Depression/Anxiety 请选择：焦虑		✔
Bipolar Disorder 双相情感障碍		✔
ADD/ADHD 注意缺陷障碍/多动症		✔
History of Eating Disorder 饮食失调史		✔
Please Circle - Cutting/Self-Harm/Suicide Attempts 请选择：是否有自我伤害或自杀的企图		✔

如实填写

Current Medications: 如实填写 _____

Any allergies to:	Yes	No
Medications Type & Reaction: 药物过敏		
Other allergies Type & Reaction: 其他过敏（请一定要如实填写）		

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

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: _____

如有心理咨询史或住院史，请详细提供具体信息。

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 手写签名 _____ Date 日期格式：月/日/年 _____

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

Signature 未满18岁同学需要家长签名 _____ Relationship _____ Date _____

此页非常重要，所有日期均需由国际旅行卫生保健中心的医师填写

（自愿免除接种的签名，由学生自行填写）

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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 #
姓	名	不填	格式：月/日/年	以930开头，在威玛寄来的邀请信上

USE DATE FORMAT OF: MM/DD/YYYY

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

MMR 麻疹/流行性腮腺炎/风疹，为强制性接种疫苗

Dose 1 given at age 12 months or later ____/____/____

Dose 2 given at least 28 days after first dose ____/____/____

A项为出生12个月以后接种，按照月/日/年，填写接种日期，医师填写

OR as individual vaccines B项为个人单独接种

Measles ____/____/____ Measles ____/____/____ Mumps ____/____/____ Mumps ____/____/____ Rubella ____/____/____

OR

Age exempt (born before 1957) for Measles/Mumps – Yes ☐ No ☐ (**Rubella is still REQUIRED**)

年龄豁免，1957年以前，此项不填。

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**

如有接种记录，请医师填写。

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): _____

Hepatitis B（乙肝疫苗），为非强制性疫苗，如不愿接种，请在此处签名。学生填写。

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

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

Tdap(百白破)疫苗，此类疫苗特指成人百白破，为强制性接种疫苗。目前国内没有，确定参加此项目的同学，均需在威玛接受补种。医师填写。

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) ___/____/____

如有接种记录，请医师填写。

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): _____

Meningococcal Tetravalent（流脑疫苗），为非强制性疫苗，如不愿接种，请在此处签名。学生填写。

E. Other vaccines NOT REQUIRED but are HIGHLY RECOMMENDED 以下疫苗为非强制性疫苗，但是强烈建议接种，

Varicella Vaccine

Dose 1____/____/____ Dose 2 ____/____/____ - OR - History of Disease ____/____/____

1.Varicella水痘疫苗 如有接种记录，请医师填写。

Human Papillomavirus Vaccine (HPV)

Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

2.HPV疫苗，是预防HPV病毒（人类乳头瘤病毒）的疫苗

Hepatitis A

Dose 1 ____/____/____ Dose 2 ____/____/____

3.Hepatits A甲肝疫苗 4.Polio脊髓灰质炎活疫苗

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.

_____ 由国际旅行卫生保健中心的医师填写并盖章 _____

DATE THIS FORM WAS COMPLETED **AN OFFICE STAMP MUST BE USED TO VALIDATE THIS FORM**

_____ 由国际旅行卫生保健中心的医师填写并盖章 _____

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

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Revised 3/2016

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III. TUBERCULOSIS RISK ASSESSMENT

Last Name	First Name	Middle Name	Date of Birth	Student ID #
姓	名	不填	格式：月/日/年	以930开头，在威玛寄来的邀请信上

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 由于中国在附属列表中，因此第四项全部填写Yes,其他几项请据实填写。
		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).**

PPD（结核菌素）检测，为强制性检测，此处请医师填写。阳性需附上胸透结果。

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.**

_____ 由国际旅行卫生保健中心的医师填写并盖章 _____
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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此页是关于申请人的身体条件是否一定需要威玛校方提供有空调的房间。由于他们的校舍负荷量有限，因此，只能满足处于特殊身体情况下的学生需求。身体状态良好的学生一般享受不到空调资源。

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.

如处于特殊身体情况，请 医师出具诊断，提供必须需要空调的证明。以下请医师填写，身体正常的同学可不填。

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 #
姓	名	不填	格式：月/日/年	以930开头，在威玛寄来的邀请信上

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!

此处请医师填写。若没有此需要，不填。

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

没有需要，此处不填。

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_____

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请依据以下提示逐条审核自己填写的表格是否符合要求。对最后一条的说明：所有同学均需在出行前统一购买出行保险，请等候项目组通知。

所用同学也均需接受威玛健康中心的管理，不得私下填写网上免除协议。否则一旦出现意外，自己承担的医疗费用将相当昂贵。

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.