



Student Health Center
Special Programs Building
University of Richmond, VA 23173
Phone (804) 289-8064 Fax (804) 287-6466

Email: Administrative: healthcenter@richmond.edu Clinical: SHCNurse@richmond.edu
Web Site: http://oncampus.richmond.edu/student_health

Dear Student:

The Student Health Center welcomes you to the University of Richmond. During your tenure at the University, we will strive to provide you with the highest quality health care. Our doctors are Board Certified Family Practice physicians, committed to students and experienced in the treatment of young adults. We understand the unique challenges of college life and believe your success, in and out of the classroom, depends on good health. To that end, we aim to educate you about health maintenance, disease prevention, and when necessary, provide treatment for illness, injury and stress. As your partner in wellness, our goals include teaching you the importance of healthy behaviors and how to be a savvy health care consumer.

In accordance with Virginia state law, you must provide information about your immunization status for certain vaccinations. **Complete the Health History Record and return it to the Student Health Center by the deadline:**

under grads - July 1, 2006

law and grads - August 1, 2006

This form will not be accepted if the healthcare provider is a family member. If you would like us to send a confirmation that your records are complete, please address and stamp the enclosed post card and return it with your Health History Record. If your medical records are deficient, we will make every effort to notify you prior to your arrival on campus.

If your records are incomplete, access to your residence hall and class registration will be blocked, and you will be required to attend a mandatory clinic at the Student Health Center during orientation.

We are here to serve students and encourage you to use our resources. If you have a chronic illness, unique medical requirements, or need referral to a local medical specialist off-campus, please call or visit the Student Health Center as soon as possible, before problems arise. Understand your health insurance plan benefits, including whether you have prescription drug coverage, and have a copy of your health insurance card when you come to the University. If you are uninsured, coverage may be purchased through the university-sponsored health plan. The Student Health Center does not have a pharmacy on site. However, Ukrops/Joe's Market pharmacy, located close to campus, participates with most health insurance prescription plans and offers free delivery Monday through Friday to the Student Health Center.

The Student Health Center operates on an appointment-based system. To make the best use of your time, students should call ahead to schedule an appointment through the Dial-A-Nurse program. We will quickly respond to your health-related questions and concerns. Our nurse will explain when treatment is needed, arrange for an appointment at the Student Health Center, or help you consult a medical specialist off campus. Complete details regarding our operation are available on the Student Health Center web site at http://oncampus.richmond.edu/student_health.

The staff of the Student Health Center is dedicated to caring for UR students. We hope to contribute in a positive way to your University experience. Accordingly, we welcome your comments about our services and encourage your ideas and suggestions.

Sincerely,

Lynne P. Deane, M.D.

Lynne P. Deane, M.D.
Medical Director

Check-list for Students and Parents

This page is for you to keep.

Health History Records Due Date: Undergrad July 1, 2006
Law/Grad August 1, 2006

Tuberculosis screening: Required for all students.

Immunizations:

Check with your doctor about the following:

Required:

- MMR (measles, mumps, rubella)
- Tetanus booster
- Polio
- Hepatitis B: (3 doses or signed waiver) : mandatory for all students
- Meningococcal meningitis vaccine or signed waiver: mandatory for undergrads

Recommended:

- Varicella (chickenpox)
- Hepatitis A

Influenza: Flu shot clinics will be announced after Fall Break

Law/Grad students – Your undergrad school is a good source for the immunization information. If you fax a release for medical records to them, it is your responsibility to verify the records have been sent to UR Student Health Center.

Pre-college health examinations:

Make sure you have a comprehensive physical examination and necessary dental and eye examinations before coming to UR.

Health Insurance:

Have appropriate medical insurance. This includes a policy providing adequate coverage while living in Richmond, VA for services such as emergency care, lab tests and x-rays. Carry your health insurance card and prescription drug card with you.

Medical records and prescriptions:

Have a record of your prescriptions, including dosages and diagnosis/reason for treatment. If you have chronic/serious medical problems, have a medical summary sent to the Student Health Center by your treating physician. Make arrangements with a local pharmacy for prescription service. Understand your prescription drug insurance coverage.

Allergy shots: The Student Health Center gives allergy shots at regularly scheduled times.

A physician's detailed orders are required. If initiating allergy shot therapy, we require the ordering physician give the first injection.

Student Health Center:

Identify available health resources on campus and be familiar with resources available for after hours emergencies. This information is on our web site at http://oncampus.richmond.edu/student_health.

First aid supplies:

Bring digital thermometer, acetaminophen, ibuprofen, cold medications, small container of band-aids, topical antibacterial cream and a chemical cold pack.

REQUIRED INFORMATION - TO BE REVIEWED BY HEALTHCARE PROVIDER
(All information must be in English)

Full name: _____ Social Security # _____

To be completed and signed by a licensed health care provider. This form will not be accepted if the healthcare provider is a family member. Any attached documents in a language other than English MUST BE TRANSLATED into English by the health care provider.

IMMUNIZATIONS [®] = required	DATES ADMINISTERED	WAIVERS/NOTES
<input type="checkbox"/> 1. Not at risk for TB exposure No skin test placed <input type="checkbox"/> 2. At risk for TB exposure TB skin test placed Date placed _____ Date read _____ Interpretation ____ pos ____ neg ____ mm induration (if none, write "0") (If pos, copy of CXR result required)	<input type="checkbox"/> 3. History of prior positive TB skin test Date positive _____ Date of chest X-ray _____ (copy of result must accompany this form) Medication(s) <input type="checkbox"/> Yes <input type="checkbox"/> No Drug name(s) _____ Treatment Dates _____	<p><i>See reverse side of this page for guidelines to completing the immunization requirements form.</i></p> <p>Hepatitis B Waiver</p> <input type="checkbox"/> I have read the information on the web site about Hepatitis B and the Hepatitis B vaccine. I understand the risks of the disease, however, I choose not to receive the vaccine. I have signed the waiver to clear my records. <input type="checkbox"/> I have not completed the series of 3 vaccines but I have signed the waiver to clear my records. Student's Printed Name: _____ UR ID#: _____ Date of Birth: _____ Signature: _____ Today's Date: _____ <i>(Parent/guardian's signature required if student is under the age of 18)</i> <input type="checkbox"/> Add my name to the list for the Hepatitis B vaccine clinic at UR on the Friday of Orientation Week.
<input type="checkbox"/> Tetanus/Diphtheria Booster Required within past 10 years <input type="checkbox"/> Td <input type="checkbox"/> Adacel _____ <div style="text-align: center;">M / D / Y</div>		
<input type="checkbox"/> Polio has received ____ doses, last dose given _____ <div style="text-align: center;">M / D / Y</div>		
<input type="checkbox"/> Hepatitis B #1 _____ #2 _____ #3 _____ <div style="display: flex; justify-content: space-around;"> M / D / Y M / D / Y M / D / Y </div> OR _____ Waiver signed.		
<input type="checkbox"/> Measles, mumps and rubella (MMR) after first birthday and April 1971 #1 _____ #2 _____ <div style="display: flex; justify-content: space-around;"> M / D / Y M / D / Y </div>		

OR

<input type="checkbox"/> Measles (Rubeola) two doses vaccine required, after first birthday and 1967.	#1 _____ #2 _____ <div style="display: flex; justify-content: space-around;"> M / D / Y M / D / Y </div>	OR Serological confirmation of immunity. Attach copy of lab results.	OR Date of Disease _____ <div style="text-align: center;">M / D / Y</div>
<input type="checkbox"/> Mumps Required; after first birthday and 1967.	_____ <div style="text-align: center;">M / D / Y</div>	OR Serological confirmation of immunity. Attach copy of lab results.	OR Date of Disease _____ <div style="text-align: center;">M / D / Y</div>
<input type="checkbox"/> Rubella Required; after first birthday and 1969.	_____ <div style="text-align: center;">M / D / Y</div>	OR Serological confirmation of immunity. Attach copy of lab results.	OR Date of Disease _____ <div style="text-align: center;">M / D / Y</div>

PLEASE NOTE:

ANY STUDENT NOT IN COMPLIANCE WITH ALL OF THE IMMUNIZATION REQUIREMENTS (labelled ®) FOR ENTRANCE TO UNIVERSITY OF RICHMOND:

- WILL HAVE CLASS REGISTRATION AND RESIDENCE HALL ACCESS BLOCKED.
- LAW STUDENTS WILL BE DISENROLLED.

<input type="checkbox"/> Meningococcal vaccine (Not required for Law and Grad Students) <input type="checkbox"/> Menomune <input type="checkbox"/> Menactra _____ <div style="text-align: center;">M / D / Y</div>	OR _____ Waiver signed.	<p align="center">Meningococcal Vaccine Waiver</p> <input type="checkbox"/> I have read the information on the web site about meningococcal meningitis and understand the risks of the disease; however, I choose not to receive the vaccine. I understand that in the event of an outbreak, unvaccinated students will be at increased risk for contracting the illness. I have signed the waiver to clear my records. <input type="checkbox"/> The vaccine is not available or I have not yet been vaccinated. I have signed the waiver to clear my records. Student's Printed Name: _____ UR ID#: _____ Date of Birth: _____ Signature: _____ Today's Date: _____ <i>(Parent/guardian's signature required if student is under the age of 18)</i> <input type="checkbox"/> Add my name to the list for the meningitis vaccine clinic at UR on the Friday of Orientation Week.
<p>RECOMMENDED IMMUNIZATIONS</p>		
<input type="checkbox"/> Varicella (Chicken Pox) #1 _____ #2 _____ <div style="display: flex; justify-content: space-around;"> M / D / Y M / D / Y </div>	OR Serological confirmation of immunity. Attach copy of lab result.	OR Date of Disease _____ <div style="text-align: center;">M / D / Y</div>
<input type="checkbox"/> Hepatitis A #1 _____ #2 _____ <div style="display: flex; justify-content: space-around;"> M / D / Y M / D / Y </div>		

All immunization dates must be verified by a health care provider or public health official with full name, signature, title and complete address and phone number. This form will not be accepted if the healthcare provider is a family member.

Signature of Health Care Provider: _____ Date: _____
 Please print or stamp examiner's name: _____ Phone: _____
 Address: _____ Fax: _____

IMMUNIZATION GUIDELINES

Complete immunization requirements **now** to prevent a **registration hold and blocked access to residence halls.**

Tuberculosis Risk Assessment	Immunization Requirements		
<p>The US Public Health Service and the Centers for Disease Control recommend that tuberculosis skin testing (Mantoux PPD) be performed on all individuals who may be at increased risk of tuberculosis disease. If any of the following statements are applicable to you, you are required to have the tuberculosis skin testing.</p> <ul style="list-style-type: none"> ▪ Unexplained weight loss ▪ Unexplained night sweats ▪ Unexplained persistent cough for more than three weeks ▪ Cough with the production of blood sputum ▪ Close contact with a known case of active tuberculosis ▪ Use of illegal injected drugs ▪ HIV infection ▪ Worked in a health care setting ▪ Resided or worked in a congregated living setting (nursing home, homeless shelter, or correctional facility) ▪ Cancer ▪ Diabetes ▪ Kidney Disease ▪ Immunosuppressive therapy ▪ Removal of part of your stomach ▪ Silicosis ▪ If you were born in or have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo PPD testing if they were born in or have arrived from any countries EXCEPT those listed below. 	<p>® MMR (Measles, Mumps, Rubella combination vaccine) Two doses both given after the first birthday, after April 1971 and at least one month apart will fulfill the measles, mumps and rubella requirement.</p> <p>® Measles (Rubeola) If given instead of MMR, documentation of one of the following is necessary: (1) Born before 1957 and therefore considered immune, or (2) Two doses of measles vaccine, both administered after 1967, after 1 year of age, and administered at least one (1) month apart (document month/day/year) (3) Physician's certification of diagnosis of measles including month and year of occurrence, or (4) Submit copy of lab result proving immunity. NOTE: Measles vaccine given before 1968 is not acceptable.</p> <p>® Mumps If given instead of MMR, documentation of one of the following is necessary: (1) Born before 1957 and therefore considered immune, or (2) Mumps vaccine given after 1 year of age and after 1967 (document month/day/year), or (3) Physician's certification of diagnosis of mumps including month and year of occurrence, or (4) Submit copy of lab result proving immunity.</p> <p>® Rubella (German Measles) If given instead of MMR, documentation of one of the following is necessary: (1) Rubella vaccine given after 1 year of age (document month/day/year), or (2) Submit copy of lab result proving immunity.</p> <p>® Hepatitis B Series of 3 vaccines given over a 6-month period OR signed waiver. If you have not had all 3 vaccines prior to submitting this form or choose not to have the vaccine at this time, sign the waiver to clear your records.</p> <p>® Tuberculosis Screening Tuberculosis screening is required of all entering students. Not all Students will require placement of the TB skin test, however. See Tuberculosis Risk Assessment for clarification.</p> <p>® Tetanus/Diphtheria Booster First booster given within 10 years of completing primary immunization Series.</p> <p>® Polio Documentation of primary immunization series requested.</p> <p>® Meningococcal Vaccine Vaccine OR signed waiver required. If you choose not to have the vaccine, sign the waiver. If vaccine is not available OR you plan to have vaccine after these forms have been submitted, <u>sign the waiver to clear your records.</u> Forward documentation once vaccine has been received.</p> <p>Strongly recommended vaccines -Varicella (chicken pox) -Hepatitis A</p>		
<table style="width: 100%; border: none;"> <tr> <td style="border: none; vertical-align: top;"> <ul style="list-style-type: none"> American Samoa Australia Belgium Canada Denmark Finland France Germany Greece Iceland Ireland Italy Jamaica Liechtenstein Luxembourg Malta Monaco </td> <td style="border: none; vertical-align: top;"> <ul style="list-style-type: none"> Netherlands New Zealand Norway Saint Kitts and Nevis Saint Lucia San Marino Sweden Switzerland United Kingdom USA Virgin Islands (USA) </td> </tr> </table>	<ul style="list-style-type: none"> American Samoa Australia Belgium Canada Denmark Finland France Germany Greece Iceland Ireland Italy Jamaica Liechtenstein Luxembourg Malta Monaco 	<ul style="list-style-type: none"> Netherlands New Zealand Norway Saint Kitts and Nevis Saint Lucia San Marino Sweden Switzerland United Kingdom USA Virgin Islands (USA) 	
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PHYSICAL EXAMINATION RECORD (physical optional only for Law and Grad students)
(To be completed by health care provider)

Full Name: _____ **Social Security #** _____

Required of NCAA athletes:

1. Sport: _____
2. Urine Screen: Urinalysis (dip) glucose _____ protein _____ blood _____
3. Blood Work: Hgb _____ Hct _____
4. Physical Exam: NCAA requirement to participate in your sport.
5. Send **original** completed form to:
Student Health Center, Special Programs Building, University of Richmond, VA 23173 (or) fax to 804-287-6466;
6. Also send a **copy** to:
 University of Richmond, Sports Medicine, 163 Robins Center, University of Richmond, VA 23173 (or) fax to 804-289-8791.

Drug Allergies: _____

Physical Examination:

Vision: (Corrected) R 20/____ L 20/____ (Uncorrected) R 20/____ L 20/____

Height: _____ (inches) Weight: _____ (pounds) B/P: ____ / ____ Pulse: _____

Normal	Abnormal			Normal	Abnormal	
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	1. HEENT
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	2. Neck
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	3. Lungs
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	4. Heart
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	5. Abdomen
						6. Genitourinary
						7. Musculoskeletal
						8. Neurological
						9. Skin

Describe any abnormalities: _____

Medical/Psychological conditions: _____

Current Medications:

Name of Medication	Dosage	Indication

Dietary Requirements: _____

Recommendations for physical activity: Unrestricted Restricted

(Explain restrictions) _____

Other Pertinent Information: _____

This form will not be accepted if the healthcare provider is a family member.

Signature of Health Care Provider _____ Date: _____

Please print or stamp examiner's name: _____ Phone: _____

Address: _____ Fax: _____