



Student Health Center, Special Programs Building,
 University of Richmond, VA 23173
 Phone: 804-289-8064 Fax: 804-287-6466
 Email: healthcenter@richmond.edu
 Web: http://oncampus.richmond.edu/student_health

FOR OFFICE USE ONLY: Complete

PPD PPD Ex Men Waiver Men Date _____

Missing: _____

Notified: _____

Entered into Banner If transfer, year of grad _____

HEALTH HISTORY RECORD – Undergraduate Students 2005-2006

(Must be completed and returned by July 1, 2005. Please keep a copy for your records)

Name _____ Male Female Date of Birth _____
Last First Middle

UR Student ID # _____ Social Security # _____
(UR ID# required)

Permanent Home Address _____
Street City State Zip Code

Country of Birth _____ Email _____
(Please print clearly)

Phone _____ Fax _____ Cell _____

If you are a visiting student?: 1 semester 1 year

If you are not a visiting student, complete the following:

Class you are entering Year you anticipate graduation from UR
(please circle)

Fr So Jr Sr _____

Are you a Yes
 NCAA Athlete? No

If YES, also send a copy of this record to:
 UR Sports Medicine, 163 Robins Center,
 University of Richmond, VA 23173 **OR**
 Fax to 804-289-8791

MEDICAL HISTORY

- | | | |
|--|--|--|
| <p>Yes No</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Allergies (annual/seasonal) <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Asthma/Exercise-Induced Asthma <input type="checkbox"/> <input type="checkbox"/> Bone/Joint Disorder <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Chickenpox <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems/Blood Clots <input type="checkbox"/> <input type="checkbox"/> Convulsions/Seizures/Epilepsy <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Eating Disorders | <p>Yes No</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Emotional Problems/Depression/Anxiety <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal Problems <input type="checkbox"/> <input type="checkbox"/> Gynecological Problems <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> Hepatitis/Liver Disease <input type="checkbox"/> <input type="checkbox"/> Kidney/Urinary Problems <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Measles (if Yes, date of illness _____) <input type="checkbox"/> <input type="checkbox"/> Mumps | <p>Yes No</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/> Mononucleosis <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Frequent Throat Infections <input type="checkbox"/> <input type="checkbox"/> Frequent Ear Infections <input type="checkbox"/> <input type="checkbox"/> Other – Explain Below |
|--|--|--|

Remarks or Additional Information: _____

Medication Allergies: _____

Previous significant illness/hospitalization/surgery (include dates): _____

Previous history of psychiatric/psychological condition (include dates): _____

Person to be notified in case of emergency: Name: _____

Address: _____ Phone Number: _____

Health Insurance Information:

Insurance Company Name _____ Policy Number _____

Member Name _____ Group Number _____

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

Full name: _____

PLEASE NOTE: ANY STUDENT NOT IN COMPLIANCE WITH THE THREE (3) MEDICAL REQUIREMENTS FOR ENTRANCE TO UNIVERSITY OF RICHMOND WILL HAVE CLASS REGISTRATION AND RESIDENCE HALL ACCESS BLOCKED.

I. REQUIRED ITEM #1 - TB SCREENING

Current guidelines of the U.S. Public Health Service and the Centers for Disease Control and Prevention recommend tuberculosis (TB) skin testing (Mantoux PPD) for all persons who may be at increased risk of TB as a result of a medical condition or previous residence in a country with an increased prevalence of TB.

A. TO THE PATIENT: Carefully complete the following TB risk assessment form. Check the box in Section 5 if none of the situations apply to you.

Section 1: Check this box if you have any of the following possible symptoms of TB.

- Unexplained elevation of temperature for more than one week
- Unexplained weight loss
- Unexplained night sweats
- Unexplained persistent cough for more than 3 weeks
- Unexplained cough productive of bloody sputum

>>You must check at least one of the 5 boxes.

Section 2: Check this box if you have any of the following risk factors for TB infection.

- Close contact with a known case of active TB
- Use of illegal injected drugs
- HIV (Human Immunodeficiency Virus) infection
- Work in a health care setting
- Resided or worked in a congregate living setting (nursing home, homeless shelter, or correctional facility)

Section 3: Check this box if you have any of the following risk factors for TB disease.

- Internal malignancy (cancer)
- Gastrectomy
- Silicosis
- Diabetes mellitus
- End-stage kidney disease
- Long-term immunosuppressive therapy
- Greater than 10% below ideal body weight

Section 4: Check this box if you have lived in or traveled to (*for more than 4 weeks*) any of the following areas with a high prevalence of TB as defined by the Centers for Disease Control and Prevention.

- Africa (all countries)
- Asia (all countries with the exception of Japan)
- Central America (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama)
- Eastern Europe (Albania, Armenia, Azerbaijan, Belarus, Bosnia/Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Poland, Romania, Russia, Serbia/Montenegro, Slovak Republic, Slovenia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan)
- Spain
- Mexico
- Middle East (Bahrain, Cyprus, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, United Arab Emirates, Yemen, Pakistan)
- South America (all countries)
- Oceania (all with the exception of Australia and New Zealand)

Section 5: No, none of the items listed in sections 1-4 apply to me.
(You are NOT required to have a PPD skin test.)

Today's Date (mo/day/yr)

The above information is true to the best of my knowledge.

Student Signature _____

REQUIRED INFORMATION – TO BE COMPLETED BY HEALTH CARE PROVIDER

Full Name: _____

B. TO THE HEALTHCARE PROVIDER:

- If patient checked any box in sections 1-4 on page 2, a Mantoux PPD skin test is required, unless previous history of positive skin test. (see B2 below).
 - Heaf and Tine tests are not acceptable.
 - Previous BCG vaccination does not exempt patient from TB skin testing.
 - Only PPD tests placed on or after the date of patient-administered TB Screening (page 2) are acceptable.
 - **Because there is significant variation in the administration and interpretation of TB skin tests between countries, the Mantoux PPD skin test must be administered in the United States.**
 - If the skin test is positive, a chest x-ray is required with a written report attached to this health history form.
 - Chest x-ray must be performed in the United States within 90 days of starting classes.

NOTE: Only PPD tests placed on or after date of patient-administered TB Screening (page 2) are acceptable.

If PPD is required (based on above assessment):

Date applied: _____ Date read: _____
(mo/day/yr) (mo/day/yr)

Reaction in millimeters: _____ mm Interpretation: Pos Neg

>>>> (Reaction must be recorded in millimeters. If no reaction, record "0".)

Mantoux PPD: 0.1cc Purified Protein Derivative (PPD) tuberculin containing 5 tuberculin units (TU) injected intradermally into the inner surface of the forearm. Record mm. of induration 48-72 hours after placement.

>>Chest x-ray and treatment recommendations REQUIRED for positive Mantoux tests. Attach copy of chest x-ray results and related reports.

2. PPD exempt if documented history of positive TB skin test:

Date Positive PPD _____ Positive PPD measurement _____ mm

Date of chest x-ray _____ (copy of report must accompany this form)

TB treatment recommended: Yes No

Dates and type of medications taken: _____

II. REQUIRED ITEM #2 - MMR VACCINATIONS

MMR (Measles, Mumps, Rubella) Two (2) are mandatory

Dose #1 _____ Dose #2 _____
Mo. Year Mo. Year

Or individual vaccines

Measles: Dose #1 _____ Dose #2 _____
Mo. Year Mo. Year

Mumps (1): _____
Mo. Year

Rubella (1): _____
Mo. Year

MMR INSTRUCTIONS:

- Only persons born before 1957 are exempt.
- Two doses are required, both given after first birthday, at least 30 days apart.
- If the combined vaccine was not given, two doses of individual rubeola (measles) vaccine given at least 30 days apart will fulfill the requirement. Alternately, a positive blood titer for rubeola (measles) is acceptable proof of immunity. (Attach report in English).
- Two doses of mumps and rubella vaccine are strongly recommended to ensure full immunity in the event of outbreaks.

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:

Signature of Health Care Provider: _____ Date: _____

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

Address: _____ Fax: _____

Any student not in compliance with the medical requirements for entrance to University of Richmond will have class registration and residence hall access blocked.

REQUIRED INFORMATION – TO BE COMPLETED BY HEALTH CARE PROVIDER

Full Name: _____

III. REQUIRED ITEM 3# - MENINGITIS VACCINE

- Virginia law requires a full-time undergraduate student to be vaccinated against meningococcal disease **OR** to sign a waiver stating that they choose not to be vaccinated after reviewing information about the vaccine's risk and effectiveness. (www.menomune.com)
- Revaccination or waiver required if vaccinated prior to August 1, 2000.
- Revaccination recommended if initial vaccine did not include serogroups A, C, Y, W-135.
- Signing waiver does not prevent a student from obtaining vaccination at a later date.
Vaccination is available at Student Health Center in August 2005.

>>You must either have been vaccinated **OR** you must sign the waiver to clear your records for entrance to UR. Sign the waiver even if you plan to receive the vaccine at a later date or at UR.

[Option 1] Date of meningococcal vaccine (one dose) _____ / _____ / _____
mo day yr

[Option 2] Signed statement below waiving vaccination

[Option 3] If vaccine is not available **OR** you plan to have vaccine after these forms have been submitted, return signed waiver to clear records. Forward documentation once vaccine has been received. If you would like to receive vaccine at UR clinic on August 19, please indicate below by checking the box.

Meningococcal Vaccine Waiver 2005-2006

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 or the vaccine is not available. I understand that in the event of an outbreak, unvaccinated students will be at increased risk for contracting the illness.

Student's Printed Name: _____ Social Security # _____

Signature: _____ Birth Date: _____ Today's Date: _____
(Parent/guardian's signature is required if student is under the age of 18.)

I have signed the waiver to clear my records. AND Add my name to the list for the meningitis clinic at UR on August 19.

IV. RECOMMENDED IMMUNIZATIONS:

Dates of Hepatitis B: #1 _____ #2 _____ #3 _____

Dates of Hepatitis A: #1 _____ #2 _____

Dates of Varicella: #1 _____ #2 _____ (If chicken pox not previously contracted)

Date of last Tetanus (Td) booster: _____

Polio (date of last in series): _____

V. List any other immunizations including dates _____

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:

Signature of Health Care Provider: _____ Date: _____

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

Address: _____ Fax: _____

Any student not in compliance with the medical requirements for entrance to University of Richmond will have class registration and residence hall access blocked.

PHYSICAL EXAMINATION RECORD
(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. To participate in your sport, the NCAA requires you must undergo a physical exam. Send original completed form to:
Student Health Center, Special Programs Building, University of Richmond, VA 23173 (or) fax to 804-287-6466;

AND ALSO SEND A COPY TO:

University of Richmond, Sports Medicine, 163 Robins Center, University of Richmond, VA 23173 (or) fax to 804-289-8791.

Medication Allergies: _____

Physical Examination:

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

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

Normal Abnormal

- | | | |
|--------------------------|--------------------------|------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. HEENT |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Neck |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Lungs |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Heart |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Abdomen |

Normal Abnormal

- | | | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Genitourinary |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Musculoskeletal |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Neurological |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Skin |

Describe any abnormalities: _____

Medical/Psychological conditions: _____

Current Medications: Name/dosage _____ Use _____
Name/dosage _____ Use _____
Name/dosage _____ Use _____
Name/dosage _____ Use _____
Name/dosage _____ Use _____

Dietary Requirements: _____

Recommendations for physical activity: Unrestricted Restricted

(Explain restrictions) _____

Other Pertinent Information: _____

Signature of Health Care Provider: _____ Date: _____

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

Address: _____ Fax: _____