



**THE COLLEGE OF WILLIAM AND MARY
STUDENT HEALTH CENTER**

P. O. Box 8795
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HEALTH EVALUATION FORM

To all full-time students entering the College of William and Mary:

Virginia state law requires all full-time students who are enrolling for the first time in a four-year public institution to provide a health history and an official immunization record. The College of William and Mary further requires ALL full-time students (including previously matriculated students) as well as any other student eligible for services as determined by their department (i.e. Language House tutors, PTUG/Flex Track students with full time hours, students with an approved underload, transfer students, or Psy. D. students) to provide documentation of meeting the same immunization requirements AND a physician documented medical history performed within the twelve months preceding his/her initial enrollment. **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 of less than 3 years must update their immunizations to meet **current** requirements. Additionally, enrolled students who are reentering as full-time students after an absence from campus of greater than 3 years must submit a new history, physical, tuberculosis screening and must update immunizations to meet the current requirements. If the absence is greater than 10 years, then the entire form needs to be resubmitted. This information **MUST** be submitted on William and Mary's Health Evaluation Form which is available @ <http://www.wm.edu/health/pdfs/greenform.pdf>

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

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

The Health Evaluation Form contains four parts, one section to be completed by you, and three sections to be completed by your licensed health care provider. You are responsible for returning your COMPLETED health evaluation form to the Student Health Center no later than July 1st for those entering the fall semester and no later than January 10th for those entering the spring semester. ALL information must be on this form. **Failure to comply with this requirement will result in the following actions: prevention from registering for classes; ineligibility for non-urgent medical care at the Student Health Center; and may also result in eviction from the residence halls and/or removal from campus (depending on the medical issue); and will include referral for judicial action for violation of the Student Code of Conduct.**

Information about your immunization record:

1. Proof of appropriate immunization is required for rubeola (measles), mumps, rubella, tetanus, diphtheria, polio, meningococcal vaccine or waiver, and Hepatitis B vaccinations or waiver. **Month, day, and year must be documented for all vaccinations.**
2. Persons born **before** 1957 are considered immune to rubeola and mumps. However, proof of appropriate immunization must be provided for the remainder of the diseases mentioned above.
3. All immunization records must be signed by a licensed practitioner **and** verified with an official stamp from a physician's office or health department. Immunization records **will not be accepted with "white-out" corrections, unsigned corrections, or notations in pencil.** This form will not be accepted if the physician completing and signing the form is a family member.
4. If official documentation of appropriate vaccination is not available, it will be necessary to repeat the vaccine(s). **Laboratory** evidence (titers) of immunity to rubeola, mumps, rubella, polio and Hepatitis B is acceptable, if copy is attached. **History of disease for required immunizations is not acceptable, except for mumps.**
5. If you must request immunization records from sources other than your own physician's office, you are responsible for making sure that these records are attached to this form and received by the Student Health Center.

REMEMBER: THE DEADLINE FOR RETURNING YOUR COMPLETED HEALTH EVALUATION FORM IS JULY 1ST FOR THOSE ENTERING FALL SEMESTER AND JANUARY 10TH FOR THOSE ENTERING SPRING SEMESTER.

If you have any questions, please do not hesitate to e-mail the Student Health Service at: sthlth@wm.edu

HEALTH EVALUATION FORM

I. HEALTH HISTORY (to be completed by student)

Please answer all questions. This information will not affect your status at William & Mary; it is strictly for the use of the Health Center in providing medical care and will not be released without your consent.

Name _____ Age _____ Birthdate _____ Gender _____
Last First Middle

Address _____ Soc. Security No. _____
Street

Student ID No. _____ Circle entering status: Fr. So. Jr. Sr. Grad. Law MBA
City State Zip Cell Phone No. _____

IF PREVIOUSLY ENROLLED, LAST YEAR ATTENDED _____ **Name if different than when you were previously here** _____

E-mail address and phone number where we may reach you before matriculation: _____
 In case of emergency, notify _____
 Relationship _____
 Address _____
 Telephone No. Home _____ Bus. _____

PERSONAL HISTORY - Please answer all questions. Leave no blank spaces.

Childhood diseases (including chickenpox) _____

Do you have any allergies? _____ If yes, please list _____

Significant medical conditions (dates and diagnoses) _____

Hospitalizations (dates and diagnoses) _____

Psychological/psychiatric treatment (dates and diagnoses) _____

Current medications and reasons for use _____

Check boxes to indicate whether you have (or had in the past) these problems. Provide details of positive answers below.

Yes	No		Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted infection
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>	Smoker
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease/murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Substance/alcohol abuse
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychological problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder
<input type="checkbox"/>	<input type="checkbox"/>	Cancer or malignancy	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or positive TB test
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Infectious mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Visual impairment
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection or stone	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other

Details _____

FAMILY HISTORY – Check if condition exists in your family (immediate family, grandparents, aunts, uncles, cousins)

_____ Allergies	_____ Cancer	_____ High Blood Pressure	_____ Sudden death	Family history of sudden death before age 50 Yes _____ No _____
_____ Anemia	_____ Diabetes	_____ Lung disease	_____ Tuberculosis	
_____ Asthma	_____ Eye disorders	_____ Psychiatric disorders	_____ Ulcer	
_____ Bleeding disorders	_____ Heart disease	_____ Stroke	_____ Other	

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 Center's website @:

<http://www.wm.edu/health/pdfs/privacypractices.pdf> and http://www.wm.edu/health/pdfs/consent_disclose_hlth_info.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, parent or guardian must sign form:

Signature _____ Relationship _____ Date _____

ATTENTION: Be advised that this form will be destroyed ten years after student leaves William and Mary.

Student Health Center

College of William and Mary P. O. Box 8795 Williamsburg, VA 23187-8795 757-221-4386 E-mail: sthlth@wm.edu

HEALTH EVALUATION FORM

III. IMMUNIZATION RECORD - VIRGINIA STATE LAW and/or the College of William and Mary REQUIRES THE FOLLOWING:

Name _____ SS# _____ Date of Birth: ____/____/____
Last First Middle Student ID# _____

A. MMR #1 after first birthday Date: ____/____/____
MMR #2 after 1980 AND after first birthday Date: ____/____/____

OR MEASLES (Rubeola) - NOTE: TWO DOSES OF MEASLES VACCINE ARE REQUIRED. (If born before 1957, considered immune)
1. Dose 1 - Immunized with live measles vaccine after 1st Birthday Date: ____/____/____
2. Dose 2 - Immunized after 1980 OR Date: ____/____/____
3. Antibody titer proving immunity. PROVIDE COPY OF REPORT

B. MUMPS - NOTE: TWO DOSES OF MUMPS VACCINE ARE REQUIRED (If born before 1957, considered immune)
1. Dose 1 - Immunized with live measles vaccine after 1st Birthday Date: ____/____/____
2. Dose 2 OR Date: ____/____/____
3. Had disease; confirmed by office record OR Date: ____/____/____
4. Antibody titer proving immunity. PROVIDE COPY OF REPORT

C. RUBELLA - REQUIRED
1. Immunized with vaccine after 1st birthday OR Date: ____/____/____
2. Antibody titer proving immunity. PROVIDE COPY OF REPORT

D. TETANUS-DIPHTHERIA - REQUIRED
1. Tetanus-diphtheria booster WITHIN THE LAST 10 YEARS OR Date: ____/____/____
2. Tdap WITHIN THE LAST 10 YEARS Date: ____/____/____

E. POLIO- REQUIRED #1 #2 #3
1. Dates of THREE doses - REQUIRED OR _____
2. Antibody titer proving immunity. PROVIDE COPY OF REPORT

F. MENINGOCOCCAL TETRAVALENT - REQUIRED - for all incoming students
Review the enclosed information about risks and effectiveness
1. Immunized with Menactra T OR Date: ____/____/____
2. Immunized with Menomune (repeat every 3-5 years) OR Date: ____/____/____
3. Waiver form signed AND attached.

G. HEPATITIS B - REQUIRED - for all incoming students
Review the enclosed information about risks and effectiveness
1. Dose 1 Date: ____/____/____
2. Dose 2 Date: ____/____/____
3. Dose 3 OR Date: ____/____/____
4. Waiver form signed AND attached OR
5. Antibody titer proving immunity. PROVIDE COPY OF REPORT

H. VARICELLA VACCINE (Recommended if no history of disease)
1. Has had disease OR Date: ____/____/____
2. Dates of vaccine Date: ____/____/____
Date: ____/____/____

I. HUMAN PAPILOMAVIRUS VACCINE (HPV) (Recommended)
1. Dose 1 Date: ____/____/____
2. Dose 2 Date: ____/____/____
3. Dose 3 Date: ____/____/____

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

*PLEASE ENSURE THAT RECORD IS SIGNED BY PRACTITIONER

HEALTH EVALUATION FORM

Name: _____

SS#: _____

IV. TUBERCULOSIS SCREENING

I. TUBERCULOSIS SCREENING ¹

1. Does the student have signs or symptoms of active tuberculosis disease? Yes ____ No ____

If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group or is the student entering the health professions?² Yes ____ No ____

If No, stop. If Yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.

3. Tuberculin Skin Test:

Date Given: ____/____/____ Date Read: ____/____/____ Lot # _____ Expiration Date _____
M D Y M D Y

Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive____ negative____

Treatment(medication prescribed and duration of treatment) _____

4. Chest X-ray - If PPD, past or present, is positive a Chest X-ray which MUST be performed in the USA is **REQUIRED within the last 12 months**. Attach copy of the report.

¹The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: <http://www.cdc.gov/tb/pubs/corecurr/index.htm>

²Categories of high risk students include those students who 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 TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

BEFORE MAILING FORM:

- _____ Complete and sign Section I
Parent/Legal Guardian **must** sign for students under 18 years of age
- _____ Examiner's signature **required** (middle of Section II)
- _____ Are all **required** immunizations documented and **signed** by a practitioner?
Are waiver forms included, if applicable?
- _____ Are all four sections included? (Sections I, II, III and IV)?
- _____ Keep a copy of the form for your records

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.

Name: _____

SSN/ID: _____

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.

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's Name/Title (M.D., R.N., P.A., N.P., D.O.)

Practitioner's 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.

Student's Signature

Date

According to Senate Bill No. 712 approved 2/16/2005, full-time students enrolled for the first time in any four-year public institution of higher education shall be vaccinated against hepatitis B. There is a provision for a waiver of this requirement if the institution of higher education provides the student detailed information on the risks associated with hepatitis B disease and the availability and effectiveness of being vaccinated.

WHAT IS HEPATITIS B?

Hepatitis B is a highly contagious virus which infects the liver. It can strike silently and cause life-threatening liver damage. People in their teens and twenties are at greater risk of contracting hepatitis B than any other age group. Hepatitis B is the most common contagious liver disease, in the United States.

HOW IS HEPATITIS B VIRUS SPREAD?

Hepatitis B virus is spread through contact with the blood and body fluids of an infected person. A person can get infected by having unprotected sex with an infected person, by sharing needles when injecting illegal drugs, by being stuck with a used needle on the job, or during birth when the virus passes from an infected mother to her baby.

WHAT ARE THE SYMPTOMS?

Often there are no symptoms, so some people have hepatitis B and never know it. Others feel very ill and are unable to work for weeks or months. Hepatitis B can be lethal. Symptoms of hepatitis B may be similar to a stomach virus.

HOW CAN COLLEGE STUDENTS PROTECT THEMSELVES?

Get vaccinated! The Centers for Disease Control (CDC) and other public health officials recommend hepatitis B vaccine for adolescents to protect them and to control hepatitis B in the United States. Young adults need to protect themselves before they become sexually active and before they are exposed to hepatitis B-before it is too late.

WHAT DOES THE VACCINATION ENTAIL?

The vaccine, an injection, is given in the arm, in three doses over a 6 month period. It is important to get all three doses to be protected. As with most vaccinations, there is some soreness in the arm for a day, but other mild side effects such as fever and nausea are rare.

WHAT IS THE EFFECTIVENESS AND THE AVAILABILITY OF THE VACCINE?

The vaccine is 80% to 100% effective in preventing infection or clinical hepatitis in those who receive the complete course of vaccine.

The vaccination is available at your private physician's office, your local health department and/or the Student Health Center at the College of William and Mary, while supplies last. There will be a fee for the immunization. At the Student Health Center the fee is \$40 per dose (price subject to change).

A written waiver must be signed by the student, or their parent or guardian if the student is a minor, and chooses NOT to be vaccinated against hepatitis B:

I _____ (print name of student) (insert Student ID Number)
ID# _____ have read the above detailed information on the risks associated with hepatitis B disease and on the availability and effectiveness of the hepatitis B vaccine. I have reviewed and understand this information.

After receipt and review of the aforementioned information on hepatitis B disease and the availability and effectiveness of the hepatitis B vaccine, I have chosen not to be vaccinated against hepatitis.

Signed Student/Parent or Guardian if the student is a minor

Date

Student's Date of Birth

Virginia House Bill 2762 approved March 19, 2001, stipulates that all incoming, full-time students at four year institutions require immunization against meningococcal disease prior to enrollment. There is a provision for a waiver of this requirement if the institution of higher education provides the student or their parent/guardian if the student is a minor, detailed information on the risks associated with meningococcal disease and the effectiveness and availability of the meningococcal vaccine. After reviewing the information below, the student or their parent/guardian, may choose not to be vaccinated against meningitis by signing and submitting the signed waiver.

WHAT IS MENINGITIS?

Meningitis is an infection of the fluid in a person's spinal cord and the fluid that surrounds the brain. People sometimes refer to it as spinal meningitis. This disease is usually caused by a viral or bacterial infection. Knowing whether meningitis is caused by a virus or bacterium is important because the severity of illness and the treatment differ. Viral meningitis is generally less severe and resolves with little treatment. Bacterial meningitis can be quite severe and may result in brain damage, hearing loss, learning disabilities or even death.

WHAT ARE THE SYMPTOMS OF MENINGITIS?

Meningitis is transmitted via air droplets and/or direct contact with an infected person. Symptoms of meningitis may mimic the flu at first with high fever, headache and stiff neck. These symptoms can develop over several hours, or they may take 1 to 2 days. Other symptoms may include nausea, vomiting or discomfort looking at bright lights. Early diagnosis and treatment are very important so that correct treatment can be started quickly.

WHY SHOULD COLLEGE STUDENTS BE VACCINATED AGAINST MENINGITIS?

Cases of meningococcal meningitis among teens and young adults 15-25 years of age have more than doubled since 1991. Over 100 cases of meningitis occur on college campuses and at least 15 students will die from the disease. College students, especially those living in dormitories, are at an increased risk of contracting the disease because of their close proximity to each other. According to the Centers for Disease Control (CDC), college freshmen living in dorms have a six times greater risk of contracting meningitis than college students overall. Virginia colleges have experienced meningitis outbreaks in the past; thankfully, William & Mary has not had an outbreak.

ARE THERE VACCINES TO PREVENT MENINGITIS?

Yes, there are two vaccines used against meningitis available to the college student: Menomune which affords protection for 3-5 years and has been available since 1981 and Menactra T which has been available since 2005 and offers protection for a longer span of time, data for revaccination is pending. These vaccines do not protect against all strains of the bacteria which cause meningitis, but they do protect against the most prevalent ones.

The meningitis vaccines are very safe, and have infrequent side effects—the most common one being soreness and redness at the site of the injection.

The vaccines may be available at your physician's office or your local health department. The Menactra T is available at the Student Health Center here at William & Mary. There will be a fee for all immunizations.

AS MENTIONED PREVIOUSLY, A WRITTEN WAIVER MUST BE SIGNED BY THE STUDENT OR THEIR PARENT/GUARDIAN, IF THE STUDENT IS A MINOR, AND CHOOSES NOT TO BE VACCINATED AGAINST MENINGITIS.

I _____ ID # _____

(Print student's name)

have read the above detailed information on the risks associated with meningococcal disease and on the availability and effectiveness of the vaccines. I have reviewed and understand this information. After reviewing this information on meningococcal disease and the availability and effectiveness of the vaccine, I have chosen not to be/have my child vaccinated against meningitis at this time.

_____ Date _____ DOB _____

(Signed student/parent/guardian)