



**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

While away at school, the Student Health Center is YOUR Primary Care Physician.  
**All full time students are eligible for services.**

Four Physicians, Board Certified in :

Infectious Disease  
Internal Medicine  
Emergency Medicine  
Family Practice

And two Nurse Practitioners

Services Offered:

- Medical Care of Acute and Chronic Illnesses
- Evaluation and Treatment of Mental Health Disorders
- Gynecological Services
- Men's Health
- Physicals (Travel, Study Abroad, etc.)
- Nutrition Counseling
- Full Service Pharmacy
- Laboratory Services
- Travel Immunizations/Vaccinations
- Allergy Injections

Most appointments can be scheduled the same day. We are here to serve YOU!

Monday-Friday 8-5 except Wednesday 10-5

**Student Health Center**



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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 physical 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 at <http://www.wm.edu/health/pdfs/healthevaluationform.pdf>

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.

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 1<sup>st</sup> for those entering the fall semester and no later than January 10<sup>th</sup> 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.**

**Do not return the Health Evaluation Form to your Department due to confidentiality concerns. Return the form to the Student Health Center only.**

**Information about your immunization record:**

1. Proof of appropriate immunization is required for rubeola (measles), mumps, rubella, tetanus, diphtheria, 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, 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 1<sup>ST</sup> FOR THOSE ENTERING FALL SEMESTER AND JANUARY 10<sup>TH</sup> 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

**Student Health Center**

## 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 \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_\_  
Last First Middle mm dd yyyy

Address \_\_\_\_\_ Soc. Security No. \_\_\_\_\_  
Street City State Zip

Cell Phone No. \_\_\_\_\_ Student ID No. \_\_\_\_\_  
 W&M entry date: \_\_\_\_\_

**Circle entering status: Undergrad. Grad Law VIMS SUMMER STUDENT ONLY**

**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 to medications or materials?** (Not seasonal/environmental) \_\_\_\_\_ 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Seasonal Allergies/Environmental Allergies		Gastrointestinal disorder		Lung disease		Sexually transmitted infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Anemia		Hearing impairment		Migraine headache		Smoker
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Asthma		Heart disease/murmur		Pneumonia		Substance/alcohol abuse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bleeding disorder		Hepatitis or liver disease		Psychological problems		Thyroid disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cancer or malignancy		High blood pressure		Rheumatoid arthritis		Tuberculosis or positive TB test
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Eating Disorder		Infectious mononucleosis		Rheumatic fever		Visual impairment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Diabetes		Kidney infection or stone		Seizure disorder		Other

Details \_\_\_\_\_

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

_____ Allergies	_____ Cancer	_____ High Blood Pressure	_____ Sudden death	<b>Family history of sudden death before age 50</b> 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 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, 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



HEALTH EVALUATION FORM

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

Name Last First Middle ID# Date of Birth mm dd yyyy

A. M.M.R. (Measles, Mumps Rubella) – REQUIRED - Both doses must be after 1st birthday.

Dose 1: \_\_\_/\_\_\_/\_\_\_ Dose 2: \_\_\_/\_\_\_/\_\_\_

Or individual vaccines - REQUIRED - Measles & Mumps both doses after 1967, and after 1st birthday.

Measles Mumps\* Rubella
Dose 1: \_\_\_/\_\_\_/\_\_\_ Dose 1: \_\_\_/\_\_\_/\_\_\_ Dose 1: \_\_\_/\_\_\_/\_\_\_
Dose 2: \_\_\_/\_\_\_/\_\_\_ Dose 2: \_\_\_/\_\_\_/\_\_\_

\*Had mumps disease; confirmation attached.

Age exempt(Born before 1957) for measles/mumps? - Yes \_\_\_No\_\_\_ (Rubella is still REQUIRED)

Or attach Laboratory proof of immunity to disease(s)

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: 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 form):

C. Tetanus-Diphtheria – REQUIRED - OR - Tdap - REQUIRED (Within last 10 years)

\_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_

D. Meningococcal Tetravalent – REQUIRED – OR - SIGN WAIVER below

All adolescents and teens ages 11-18 y/o should be vaccinated with Menactra or Menveo, as should unvaccinated adults who are attending college. Booster doses will be necessary for those who got their first dose before age 16 v/o.

Immunized with: 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.htm 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 immunized against Meningitis infection at this time. Student signature (If you are under 18, parent or guardian must sign form):

E. Varicella Vaccine – Recommended if no history of disease

Dose 1: \_\_\_/\_\_\_/\_\_\_ Dose 2: \_\_\_/\_\_\_/\_\_\_ OR History of disease \_\_\_/\_\_\_/\_\_\_

F. Human Papillomavirus Vaccine (HPV) – Recommended

Dose 1: \_\_\_/\_\_\_/\_\_\_ Dose 2: \_\_\_/\_\_\_/\_\_\_ Dose 3: \_\_\_/\_\_\_/\_\_\_

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

Student Health Center

HEALTH EVALUATION FORM

**IV. TUBERCULOSIS Risk Assessment**

Name: \_\_\_\_\_

ID#: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No 1. Do you have any of the following symptoms? Please circle

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>▪ Persistent Cough</li> <li>▪ Night sweats</li> <li>▪ Bloody sputum</li> <li>▪ Chills</li> </ul> | <ul style="list-style-type: none"> <li>• Unexplained fever for more than one week</li> <li>• Fatigue</li> <li>• Loss of appetite</li> <li>• Unexplained weight loss</li> </ul> |
|---|--|

\_\_\_ Yes \_\_\_ No 2. Do any of these situations apply to you?

- \* History of positive PPD testing – see note bottom of this page
- Close contact with a known or suspected case of tuberculosis
- Use of illegal 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)

\_\_\_ Yes \_\_\_ No 3. Do you have any of the following health conditions that place you at increased risk for disease if infection occurs?

Silicosis, Diabetes mellitus, end stage renal disease/chronic renal failure, some hematologic disorder, other malignancies, low body weight, prolonged corticosteroid use, use of other immunosuppressive treatments, organ transplantation, gastrectomy or jejunioileal bypass, chronic malabsorption syndromes.

\_\_\_ Yes \_\_\_ No 4. Were you born in another country listed on Table 1 (next page) AND arrived in the U.S. within the past 5 years?

Please list country \_\_\_\_\_.

\_\_\_ Yes \_\_\_ No 5. Have you traveled within the last 5 years to one or more of the countries listed in Table 1 (next page) with stay exceeding 4 weeks? If yes, please list the country/ies: \_\_\_\_\_

\*\*\*\*\* If you answered “no” to questions 1 – 5, TB testing is NOT required.

\_\_\_ If you answered “yes” to any question above, TB testing is required. PRIOR BCG vaccine does not exempt one from this requirement.

\_\_\_ If “yes” to question 5, and have had TB testing since your return, indicate date of testing and result below. \*\*

<p><b>**TB (PPD) Skin Test</b></p> <p>Date Administered: ___/___/___</p> <p>Date Test Read: ___/___/___</p> <p>Result ___ mm of induration</p> <p>Interpretation: Positive__ Negative__</p> <p><b>OR –</b></p> <p><b>Equivalent blood test result _____</b></p> <p><b>(attach report)</b></p>	<p><b>Chest X-Ray</b></p> <p>Required if TB test is positive</p> <p>_____</p> <p>Date of X-ray</p> <p>Result: NEG      POS</p> <p>(attach copy of written report)</p>	<p><b>Preventative Treatment</b></p> <p>Preventative Treatment discussed _____</p> <p>Drug Prescribed _____</p> <p>Duration _____</p> <p>Patient declined _____</p>
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**\*If history of positive PPD, Chest x-ray required and attach copy of written report .**

\_\_\_\_\_  
SIGNATURE OF HEALTH PROFESSIONAL

\_\_\_\_\_  
DATE THIS FORM WAS COMPLETED

**Student Health Center**

## Table 1

(Source: World Health Organization)

Afghanistan	Guinea	Papua New Guinea
Algeria	Guinea-Bis	Paraguay
Angola	Guyana	Peru
Anguilla	Haiti	Philippines
Argentina	Honduras	Poland
Armenia	India	Portugal
Azerbaijan	Indonesia	Qatar
Bahamas	Iran	Romania
Bahrain	Iraq	Russian Fed.
Bangladesh	Japan	Rwanda
Belarus	Kazakhstan	St. Vincent & The Grenadines
Belize	Kenya	Sao Tome & Principe
Benin	Kiribati	Saudi Arabia
Bhutan	Korea-DPR	Senegal
Bolivia	Korea-Rep	Seychelles
Bosnia & Herzegovina	Kuwait	Sierra Leone
Botswana	Kyrgyzstan	Singapore
Brazil	Lao PDR	Solomon Is.
Brunei Darus.	Latvia	Somalia
Bulgaria	Lesotho	South Africa
Burkina Faso	Liberia	Spain
Burundi	Lithuania	Sri Lanka
Cambodia	Macedon-TFYR	Sudan
Cameroon	Madagascar	Suriname
Cape Verde	Malawi	Syrian Arab Republic
Cent. African Rep	Malaysia	Swaziland
Chad	Maldives	Tajikistan
China	Mali	Tanzania UR
Columbia	Marshall Is.	Thailand
Comoros	Mauritania	Timor-Leste
Congo	Mauritius	Togo
Congo DR,	Mexico	Tokelau
Coted'Ivoire	Micronesia	Tonga
Croatia	Moldova-Rep	Tunisia
Djibouti	Mongolia	Turkey
Dom Republic	Montenegro	Turkmenistan
Ecuador	Morocco	Tuvalu
Egypt	Mozambique	Uganda
El Salvador	Myanmar	Ukraine
Equ Guinea	Namibia	Uruguay
Eritrea	Nauru	Uzbekistan
Estonia	Nepal	Vanuatu
Ethiopia	New Caled.	Venezuela
Fiji	Nicaragua	Vietnam
French Poly Gabon	Niger	Wallis & Futuna Is
Gambia	Nigeria	West Bank & Gaza Strip
Georgia	Niue	Yemen
Ghana	N. Mariana Is.	Zambia
Guam	Pakistan	Zimbabwe
Guatemala	Palau	
	Panama	

### Student Health Center

Name: \_\_\_\_\_

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 1<sup>st</sup> 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.**

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

**Student Health Center**

BEFORE MAILING FORM:

**Please note:** Your Student ID number is located on your acceptance letter, and is helpful in processing your Health Evaluation 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 and Section IV).
- \_\_\_\_\_ Are all **required** immunizations documented and **signed** by a practitioner?  
Are waiver forms SIGNED, if applicable?
- \_\_\_\_\_ Are all four sections included? (Sections I, II, III and IV)?
- \_\_\_\_\_ Keep a copy of the form for your records
- \_\_\_\_\_ Include a copy of the front and back of your insurance card (unless you have the College insurance plan). This information is needed for any outside referral should it be necessary.  
**PLEASE NOTE: YOU ARE STILL REQUIRED TO SUBMIT AN INSURANCE WAIVER**

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.

**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!

**Student Health Center**