



**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
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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/healthevaluationform.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

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

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

Address _____ Soc. Security No. _____
Street

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

Student ID 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 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	Seasonal Allergies/Environmental Allergies	Yes	No	Gastrointestinal disorder	Yes	No	Lung disease	Yes	No	Sexually transmitted infection
		Anemia			Hearing impairment			Migraine headache			Smoker
		Asthma			Heart disease/murmur			Pneumonia			Substance/alcohol abuse
		Bleeding disorder			Hepatitis or liver disease			Psychological problems			Thyroid disorder
		Cancer or malignancy			High blood pressure			Rheumatoid arthritis			Tuberculosis or positive TB test
		Eating Disorder			Infectious mononucleosis			Rheumatic fever			Visual impairment
		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	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/offices/healthcenter/documents/privacypractices.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 _____

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

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* Rubella
Dose 1: Dose 1: Dose 1:
Dose 2: Dose 2:

*Had mumps disease; confirmation attached.

Age exempt for measles/mumps? (Rubella is still REQUIRED) Yes No
(Born before 1957)

Or attach Laboratory proof of immunity

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

C. Polio – 3 doses REQUIRED - Or attach Laboratory proof of immunity

Dose 1: Dose 2: Dose 3:

D. Hepatitis B – REQUIRED – Or attach Laboratory proof of immunity or sign waiver

Dose 1: Dose 2: Dose 3:

Or Merck 2 dose adolescent series: Dose 1: Dose 2:

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):

E. Meningococcal Tetravalent – REQUIRED – or sign waiver

Immunized with Menactra T Or

Immunized with Menomune (repeat every 3-5 years) Or

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):

F. Varicella Vaccine – Recommended if no history of disease

Dose 1: Dose 2: Or History of disease

G. 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

*PLEASE ENSURE THAT RECORD IS SIGNED BY PRACTITIONER

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HEALTH EVALUATION FORM

IV. TUBERCULOSIS SCREENING

Name: _____

ID#: _____

Please answer the following questions:

1. Have you ever had a **positive** TB skin test? ____ Yes ____ No
 If **yes**, provide most recent chest xray result and treatment prescribed by completing boxes below. **DO NOT answer questions 2-4.**
 If **No**, answer questions, 2-4.
2. Have you ever had close contact with anyone who was sick with Tuberculosis? ____ Yes ____ No
3. Were you born in one of the countries listed below and arrived in the U.S within the past 5 years? (Please circle country) ____ Yes ____ No
4. Have you ever traveled to one or more of the countries listed below with stay exceeding 4 weeks? (If yes, please CIRCLE the country/ies) ____ Yes ____ No

IF YES TO ANY QUESTION 2-4, PPD REQUIRED WITHIN THE PAST 12 MONTHS. IF NO TO QUESTIONS 2-4, PPD IS not REQUIRED.

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

(Source: World Health Organization)

TB (PPD) Skin Test	Chest X-Ray	Treatment
Date Administered: ____/____/____	Required if TB skin test is positive	Prescribed _____
Date Test Read: ____/____/____	Date of X-ray	Duration _____
Result ____ mm of induration	Result: NEG POS	Student declined _____
Interpretation: Positive__Negative__ If positive, Chest xray required and attach copy of written report	(attach copy of written report)	Discuss options at Student Health Center _____

Student Health Center

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

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 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 your insurance card (front and back). 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.