



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

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**Summer Student  
HEALTH EVALUATION FORM**

To all College of William and Mary summer students:

*Welcome!*

For those students who may be seeking care at the Student Health Center, Sections I, II, III and IV of the Health Evaluation Form **must** be completed (a summer fee will be incurred). This information **MUST** be submitted on William and Mary's Health Evaluation Form.

The College of William and Mary **requires** a Health History (**Section I** must be completed) an official immunization record (**Section III** must be completed) and Tuberculosis Screening (**Section IV** must be completed) of **ALL** students residing in campus housing. We will accept official documentation of immunizations and Tuberculosis Screening that you may have provided to other educational institutions.

You are responsible for returning your completed health evaluation form to the Student Health Center no later than **TWO** weeks prior to the beginning date of the program that you are entering. **DO NOT** return the Health Evaluation Form to your department due to confidentiality concerns, return the form to the Student Health Center **ONLY**.

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

**Failure to comply with this Health Evaluation Form requirement may result in eviction from the residence halls and/or removal from campus (depending on the medical issue).**

**Information about your immunization record:**

1. Proof of appropriate immunization is required for rubeola (measles), mumps, rubella, tetanus, diphtheria, polio, meningococcal or waiver and hepatitis B vaccines 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. Faxed copies of immunizations will only be accepted if originated from other medical offices. This form will not be accepted if the physician/practitioner 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 and rubella, polio and Hepatitis B is acceptable, if a 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.

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

**Student Health Center**



# HEALTH EVALUATION FORM

## II. PHYSICAL DOCUMENTATION

TO THE LICENSED HEALTH PROFESSIONAL (D.O., M.D., P.A., N.P.) PERFORMING THIS EVALUATION: Please review the student's history (Part 1), and provide additional details as needed.

Please complete the following.

Name \_\_\_\_\_  
Last First Middle DOB mm / dd / yyyy

Height \_\_\_\_\_ inches Weight \_\_\_\_\_ lbs. BP \_\_\_\_\_ Pulse \_\_\_\_\_ Vision R 20/ \_\_\_\_\_ L20/ \_\_\_\_\_

**HISTORY:** Are there any conditions of which we should be aware? Describe fully. Use additional sheet if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A. Is there loss or impairment of any paired organ? No \_\_\_\_\_ Yes (explain) \_\_\_\_\_

B. Recommendation for physical activity (Phys. Ed., Intramurals, Intercollegiate athletics, etc.) Unlimited \_\_\_\_\_  
Limited (explain) \_\_\_\_\_

C. If this student has a medical condition that requires the use of air conditioning, please complete the attached form.

D. Do you have any recommendations regarding the medical care of this student? No \_\_\_\_\_ Yes (explain) \_\_\_\_\_

\_\_\_\_\_  
\*Examiner's Signature Street City Zip Code

\_\_\_\_\_  
Examiner's Name (PRINTED) Telephone Date

*Please ensure that Examiner signs form!*

E. Has this student been treated for any psychological or psychiatric condition? No \_\_\_\_\_ Yes (explain) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Specific diagnosis \_\_\_\_\_

Medication and doses \_\_\_\_\_

Name, address, phone number of mental health professional: \_\_\_\_\_

\_\_\_\_\_

**ATTENTION: 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 \_\_\_\_\_ ID# \_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_
Last First Middle 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. 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 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): \_\_\_\_\_

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

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

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

- |                    |  |
|--------------------|--|
| ▪ Persistent Cough | • Unexplained fever for more than one week |
| ▪ Night sweats     | • Fatigue                                  |
| ▪ Bloody sputum    | • Loss of appetite                         |
| ▪ Chills           | • Unexplained weight loss                  |

\_\_\_ 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 jejunoileal 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. \*\*

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

**\*If history of positive PPD, Chest x-ray required and attach copy of written report .**

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

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

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TABLE 1

(Source: World Health Organization)

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

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