



**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

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

_____ Student ID No. _____
City State Zip

Cell Phone 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	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 Ctr website@ [\1SHC-DOCUMENTS\d-Patient Notice of Privacy Practices.doc](#)

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 _____ 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

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

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

***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	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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