

# Ferrum College Health Form



To all students:

Based on a recommendation from the Virginia Department of Health and the American College Health Association, Ferrum College requires that current health and immunization records be on file for all students. Information contained herein is confidential as a part of your records and will not be disclosed without your written permission, except in the event of an emergency.

### To Be Completed By Student

Name \_\_\_\_\_ SS# \_\_\_\_\_  
(Last) (First) (Middle) Student ID#

Sex \_\_\_\_ Marital Status \_\_\_\_ Date of Birth \_\_\_\_\_ College Entrance Date \_\_\_\_\_ Freshman \_\_\_\_ Transfer \_\_\_\_

Home Address \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip Code)

In case of emergency, please notify:

\_\_\_\_\_  
(Name) (Relationship) (Home/Work Telephone Number)

\_\_\_\_\_  
(Address) (Cell Phone Number)

Primary Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Group Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Group Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone \_\_\_\_\_

Note: If prior authorization is needed, please list name and phone number of Primary Care Physician

\_\_\_\_\_  
(Name) (Phone)

### Student Must Answer All Questions

**Has anyone in your immediate family had any of the following conditions?**

Tuberculosis	No _____	Yes _____	Who? _____
Diabetes	No _____	Yes _____	Who? _____
Kidney Disease	No _____	Yes _____	Who? _____
High Blood Pressure	No _____	Yes _____	Who? _____
Cancer	No _____	Yes _____	Who? _____
Epilepsy	No _____	Yes _____	Who? _____
Heart Attack	No _____	Yes _____	Who? _____
Stroke	No _____	Yes _____	Who? _____
Sudden Death	No _____	Yes _____	Who? _____

\_\_\_\_\_  
(Cause)

\_\_\_\_\_  
(Age)

**Your Personal Medical History** (Check "yes" or "no" and explain all "yes" answers in the spaces following the list.) (Please attach additional pages if necessary.)

Scarlet Fever	No ___ Yes ___	Measles	No ___ Yes ___	Whooping Cough	No ___ Yes ___
Chickenpox	No ___ Yes ___	Diabetes	No ___ Yes ___	Thyroid Disease	No ___ Yes ___
Rheumatic Fever	No ___ Yes ___	Stomach Problems	No ___ Yes ___	Pneumonia	No ___ Yes ___
Fatigue	No ___ Yes ___	Depression/Anxiety	No ___ Yes ___	Mumps	No ___ Yes ___
Mono	No ___ Yes ___	Kidney Infection	No ___ Yes ___	Epilepsy	No ___ Yes ___
Hypertension	No ___ Yes ___	Heart Murmur	No ___ Yes ___	Asthma	No ___ Yes ___
Fainting Spells	No ___ Yes ___	Hepatitis	No ___ Yes ___	Migraines	No ___ Yes ___
Hernia	No ___ Yes ___	Blood in Urine	No ___ Yes ___	Protein in Urine	No ___ Yes ___
Anemia	No ___ Yes ___	Abnormal Bruising	No ___ Yes ___	Sickle-Cell Disease	No ___ Yes ___
Hearing Problems	No ___ Yes ___	Heart Disease	No ___ Yes ___	Abnormal Heart Beat	No ___ Yes ___
Undescended Testicle	No ___ Yes ___	Scoliosis	No ___ Yes ___	Suicidal Thoughts	No ___ Yes ___
Menstrual Problems	No ___ Yes ___			Counseling	No ___ Yes ___

List and give dates of any serious injuries, hospitalizations, illnesses or operations: \_\_\_\_\_

Describe any emotional disturbances or adjustment problems \_\_\_\_\_

List any medications you are currently taking, including dosage and scheduled administration \_\_\_\_\_

**Terms**

Information on this form may be necessary in the event of an emergency. Failure to provide this information may result in delay or difficulty administering medical care. All omissions or incomplete information on this form are the responsibility of the student and his/her health care provider. This completed form must be filed at the FCHC on the college campus at the beginning of the school year.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Immunizations**

**Required Immunizations**

MMR#1 Date: \_\_\_\_\_ MMR#2 Date: \_\_\_\_\_ OR Titer Date and Result \_\_\_\_\_

Tetanus Date: \_\_\_\_\_ (must be within last 7 years) Polio (completed) Yes \_\_\_ No \_\_\_

**Tuberculosis Screening** (complete both questions 1 and 2)

- Does the student have signs or symptoms of active TB disease? Yes \_\_\_ No \_\_\_  
If No, proceed to question 2.  
If YES, proceed with additional evaluation to exclude active TB including TB skin test, CXR and Sputum evaluation as indicated.
- Is the student a member of a high-risk group or is the student entering the health profession? Yes \_\_\_ No \_\_\_  
If YES, perform TB skin test (Mantoux only).

**Tuberculin Skin Test** (within one year) Date given \_\_\_\_\_ Date read \_\_\_\_\_ Induration \_\_\_\_\_ mm  
Positive \_\_\_ Negative \_\_\_ **Chest X-ray** (required if skin test is positive) Date \_\_\_\_\_ Report Results \_\_\_\_\_

**Hepatitis B series**  
(Dates of shots) #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**Recommended (but not required) Immunization**

**Meningitis verification of shot or signed waiver.** Date of shot \_\_\_\_\_  
I have received and reviewed the Ferrum College Statement on Recommended Immunizations. I have been informed and understand the benefits of the meningococcal vaccine and decline to receive the immunization.  
Student's signature for waiver \_\_\_\_\_ Date \_\_\_\_\_

All omissions or incomplete information on this form is the responsibility of the student and his/her health care provider.

**Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Provider's Last Name (Print)** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Telephone** \_\_\_\_\_