

Student Name: _____ DOB: _____ College I.D. # _____

FERRUM COLLEGE STUDENT HEALTH FORM

Dear Ferrum College Student:

Welcome! The Office of Student Life and Engagement congratulates you on your acceptance to Ferrum College! Our team is here to help you promote your well-being and to restore your health in the event of illness, or a mental health concern. OSLE also includes Counseling and Psychological Services. Medical Services are provided by Tri-Area Community Health Center and Pharmacy, 180 Ferrum Mountain Rd, Ferrum, VA 24088.

Completion of the pre-entrance health form (included in the following pages) allows you to demonstrate that you have met the basic immunization requirements known to promote healthy communities, as required to enter Ferrum College. Information contained herein is confidential as part of your records and will not be disclosed without your written permissions, except in the event of an emergency. Information on this form may be shared with the Virginia Department of Health as needed, and/or, our contracted college health provider, Tri-Area Community Health.

Please note the following requirements:

- 1. Designated Emergency Contact(s):** May be your parent, guardian, spouse, or next-of-kin who could be of support to you, or assist with medical decision making in the event you are unable to speak for yourself.
- 2. Exemptions to Immunizations:** On occasion, a student may elect to opt out of vaccine requirements based on their religious beliefs or medical reasons (TB testing is still required).
- 3. Certificate of Immunization & Tuberculosis Screening/Testing:** These must be completed by your healthcare provider. All students are required to have the tuberculosis screening completed.

Sincerely,

The Office of Student Life and Engagement

Student Name: _____ DOB: _____ College I.D. # _____

INSTRUCTIONS FOR COMPLETING IMMUNIZATION INFORMATION

Marking: Please print using black ink. Read carefully and fill in all applicable information. **All information regarding Immunization and Tuberculosis screening/testing must be in English.**

Immunizations: To be completed and signed by a Health Care Provider

Required vaccinations/screening for all students:

A. Measles, Mumps, Rubella (MMR): Two doses of MMR or individual vaccines **of each required**, at least 4 weeks apart, given on or after the first birthday. Not required if born before 1957. Titers proving immunity are acceptable; please provide a copy of the report with the date(s) and result(s) of positive titer(s).

B. Tetanus Diphtheria-Pertussis: Primary series (DTap, DTP, DT or Td) plus booster **within the last 10 years of fall entry or spring entry.** Tdap is the preferred one time booster. Tdap may be given regardless of interval since last Td.

C. Poliomyelitis (OPV) or (IPV): Completed primary series is required. Please provide all dates as well as any boosters received since that date. A titer proving immunity is acceptable; please provide the date of a positive titer; please provide a copy of the report with the date and result of positive titer.

D. Hepatitis B: Students must have documentation of a completed vaccination series. The Twinrix immunization series is an acceptable alternative, as is a titer proving immunity (please provide a copy of the report with the date and result of positive titer). Students may choose to sign a waiver for this immunization.

E. Meningococcal Vaccine: For students younger than 22 years of age, one dose of vaccine required after age 16 or signed waiver. Meningitis B vaccines (Trumenba and Bexsero) do not meet this requirement.

F. Tuberculosis Screening/Testing: "Tuberculosis Screening" is required for **all students.**

Recommended but not required:

A. HPV (Quadrivalent or Bivalent) Vaccine: The three-shot series is recommended for all females ages 11-26 and males ages 11-21. It is also approved for males up to age 26 in certain situations, see **CDC guidelines.**

B. Meningococcal B Vaccine: For best protection, more than 1 dose of meningococcal B vaccine is needed. There are two meningococcal B vaccines available. The same vaccine must be used for all doses. The vaccine can help protect against meningococcal disease caused by serogroup B.

F. COVID-19 Vaccine: Completed two doses of either the Pfizer-BioNTech COVID-19 vaccine OR the Moderna COVID-19 vaccine OR a single dose of the Johnson & Johnson (also known as Janssen Biotech) COVID-19 vaccine. COVID-19 vaccines authorized by the World Health Organization (e.g., AstraZeneca/Oxford and Sinopharm) are also acceptable.

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Pre-Entrance Health Form: PART I

[TO BE COMPLETED BY INCOMING STUDENT OR PARENT/LEGAL GUARDIAN please print]
(PLEASE NOTE - THIS FORM IS DIFFERENT FROM THE STUDENT ATHLETE PHYSICAL**)**

Name _____
(Last) (First) (Middle)

Date of Birth: ____/____/____ College ID# _____ State or Country of Birth: _____

Address: _____
Street City State Zip

Student Cell Phone ____ - ____ - ____ Student Alternate Phone Number ____ - ____ - ____ (home work)

Name of Parent or Legal Guardian 1: _____ Phone ____ - ____ - ____ Work or Cell ____ - ____ - ____

Name of Parent or Legal Guardian 2: _____ Phone ____ - ____ - ____ Work or Cell ____ - ____ - ____

Emergency Contact: _____ Phone ____ - ____ - ____ Work or Cell ____ - ____ - ____

****Student Must Answer All Questions**** **Personal Medical History**

Have you ever had the following?

Asthma/Bronchitis	No__	Yes__	Diabetes	No__	Yes__	Mental Health Issues	No__	Yes__
Chickenpox	No__	Yes__	Thyroid Disease	No__	Yes__	ADD/ADHD	No__	Yes__
Hypertension	No__	Yes__	Mono	No__	Yes__	Depression/Anxiety	No__	Yes__
Heart Disease/Murmur	No__	Yes__	Abnormal Bruising	No__	Yes__	Suicidal Thoughts	No__	Yes__
Fainting/Dizzy Spells	No__	Yes__	Anemia	No__	Yes__	Eating Disorder	No__	Yes__
Epilepsy/Seizures	No__	Yes__	Hepatitis	No__	Yes__	Migraines/Chronic Headaches	No__	Yes__
Head Injury/Concussions	No__	Yes__	STD	No__	Yes__	Obesity	No__	Yes__
Irritable Bowel	No__	Yes__	Menstrual Problems	No__	Yes__	Hearing Problem	No__	Yes__

Details of above, if necessary: _____

Please complete the following:

List dates of any serious injuries, hospitalizations, illnesses or operations.

Circle **NONE** or, if applicable, please list _____

Describe any emotional disturbances or adjustment problems.

Circle **NONE** or, if applicable, please list _____

List any medications you are currently taking.

Circle **NONE** or, if applicable, please list _____

Are you allergic to any medications? YES ____ NO ____ Specify: _____

Information on this form may be necessary in the event of an emergency. All omissions or incomplete information on this form are the responsibility of the student and his/her healthcare provider. This completed form must be on file with Ferrum College at the beginning of the school year. **I affirm that all of the above information is accurate.**

Student Name: _____ Signature: _____ Date: _____

Student Name: _____ DOB: _____ College I.D. # _____

Pre-Entrance Health Form: PART II

[TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER.]

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.

REQUIRED IMMUNIZATIONS				
Measles,Mumps,Rubella (MMR)	Dose #1 Date: (MM/DD/YY) ____/____/____	Dose #2 Date: (MM/DD/YY) ____/____/____	OR Titer (Attach Copy)	
Tetanus	Date: (MM/DD/YY) ____/____/____ (Date must be within the past 10 years)			
Poliomyelitis (OPV) or (IPV)	Dose #1 Date: (MM/DD/YY) ____/____/____	Dose #2 Date: (MM/DD/YY) ____/____/____	Dose #3 Date: (MM/DD/YY) ____/____/____	Dose #4 Date: (MM/DD/YY) ____/____/____
Hepatitis B	Dose #1 Date: (MM/DD/YY) ____/____/____	Dose #2 Date: (MM/DD/YY) ____/____/____	Dose #3 Date: (MM/DD/YY) ____/____/____	Booster if applicable Date: (MM/DD/YY) ____/____/____
Meningococcal Vaccine Initial dose OR a booster dose must have been received <u>on or after their 16th birthday</u>	Dose #1 Date: (MM/DD/YY) ____/____/____		Dose #2 Date: (MM/DD/YY) ____/____/____	
RECOMMENDED BUT NOT REQUIRED				
HPV (Quadrivalent or Bivalent)	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	Date: (MM/DD/YY) 3) ____/____/____	
Meningococcal B Vaccine	Date: (MM/DD/YY) 1) ____/____/____	Date: (MM/DD/YY) 2) ____/____/____	Date: (MM/DD/YY) 3) ____/____/____	
COVID-19	Dose #1 Date: (MM/DD/YY) ____/____/____	Dose #2 Date: (MM/DD/YY) ____/____/____	Booster if applicable Date: (MM/DD/YY) ____/____/____	

Required Tuberculosis Screening (all students):				
Does the student have signs or symptoms of active TB disease?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
Is the student a member of a high-risk group?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
Tuberculosis Testing Result. Required only if TB Screening Positive.	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Test method: <input type="checkbox"/> IGRA <input type="checkbox"/> PPD	Date of test:	Must attach copy of result for IGRA.
Chest X-ray result. Required only if Tuberculosis Testing Positive.	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date of test:	Must attach copy of report.
All students with a positive IGRA or TST and no signs of active disease on chest x-ray should receive education and treatment recommendations for Latent Tuberculosis Infection (LTBI).				

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL:

Physician/PA/NP/RN/Health department official: _____

Physician/PA/NP/RN/Health department official (print) _____ Date: _____

Address: _____ Phone: _____ - _____ - _____

**Return to: Office of Student Life and Engagement
Attention: Sandy Pagans, Coordinator of Student & Family Support
P.O.Box 1000, Ferrum, VA 24088**

