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.

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

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 for 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 on or after their 16th birthday	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?	□YES	□NO		
Is the student a member of a high-risk group?	□YES	□NO		
Tuberculosis Testing Result. Required only if TB Screening Positive.	Result: □ Positive □ Negative	Test method: □ IGRA □ PPD	Date of test:	Must attach copy of result for IGRA.
Chest X-ray result. Required only if Tuberculosis Testing Positive.	□ Positive	□ 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

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

Waiver of Immunization Against Hepatitis B Disease

The Hepatitis B virus (HBV) may cause a serious liver disease. HBV infection can affect people of all ages, and lead to liver disease. Some people are never able to rid themselves of the virus, and this long-term, or chronic, HBV infection can cause chronic liver disease, liver cancer, and death. The virus is found in the blood and body fluids of infected people and is most often spread among adults through sexual contact or by sharing needles and other drug paraphernalia with an infected person. HBV can also be spread in households of HBV-infected persons or by passage of the virus from an HBV-infected mother onto her infant during birth. Hepatitis B can be a silent disease, often infecting many people without making them feel sick. Unfortunately, 30 percent of those infected with HBV are not aware that they are carriers and can infect others. Hepatitis B symptoms might include loss of appetite, fatigue, stomachache, nausea and vomiting, yellow of the whites of the eyes (jaundice), and/or joint pain. Vaccination can help prevent people from contracting hepatitis B. The HBV vaccine is 96 percent effective following a series of three shots over a six-month period. The most common side effect of the vaccine is soreness at the injection site. Vaccine recipients cannot get the disease from the vaccine.

☐ I have received and reviewed the information regarding hepatitis B and the availability and effectiveness of the hepatitis B vaccine. I have chosen not to be vaccinated against hepatitis B at this time.

_____ _____

Signature of student Date Signature of parent/ guardian if student is a minor Date

Waiver of Immunization Against Meningococcal Disease

Meningitis is an inflammation of the linings of the brain and spinal cord. It can be caused by bacteria called Neisseria meningitidis. The bacteria are transmitted through air-borne droplets of respiratory secretions and by direct contact with infected persons. Although bacterial meningitis occurs rarely and sporadically throughout the year, increased outbreaks occur among college students, especially those who live in residence halls. Early symptoms of meningococcal disease include fever, severe headache, stiff neck, rashes, and exhaustion. If not treated early, meningitis can lead to severe and permanent disabilities or even death. A vaccine is available that protects against four strains of the bacteria that cause meningitis in the United States: types A,C,Y, and W-135. These types account for nearly two-thirds of meningitis cases among college students. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days. The vaccine is 85 to 100 percent effective.

☐ I have received and reviewed the information regarding meningococcal disease and the availability and effectiveness of the meningococcal vaccine. I have chosen not to be vaccinated against meningococcal disease at this time.

_____ _____

Signature of student Date Signature of parent/ guardian if student is a minor Date