FERRUM COLLEGE STUDENT HEALTH FORM

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 part of your records will not be disclosed without your written permission, except in the event of an emergency.

(THIS FORM IS DIFFERENT FROM THE STUDENT ATHLETE PHYSICAL)

TO BE COMPLETED BY THE STUDENT (please print)

Name _____ _____

(Last) (First) (Middle) Student ID#

Sex ____Martial Status _____ Date of Birth _____ College Entrance Date _____ Freshman___ Transfer___

Home Address _____

(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____

****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: _____

Terms

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 filed on the college campus at the beginning of the school year.

Student Signature _____

Date _____

Continue to the back of the form

Required Immunizations

****MUST BE COMPLETED AND SIGNED BY A PHYSICAN****

An official copy (high school transcript, health department, medical provider) of the following immunizations must be attached to this health 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) ____/____/____

- **Tuberculosis Screening REQUIRED** (complete both question 1 and 2)

    1. Does the student have signs or symptoms of active TB disease? NO_____ YES _____
    2. Is the student a member of a high-risk? NO_____YES _____

- **Tuberculin Skin Test** (If needed and must be within one year) Date given _____Date read_____

  Induration _____mm Positive _____ Negative _____

  Chest X-ray (required if skin test is positive) Date _____ Report Results _____

THIS FORM WILL NOT BE ACCEPTED IF NOT SIGNED BY A HEALTH CARE PROVIDER.

Physician/PA/NP Signature _____ **Date** _____

Physician/PA/NP Name (print) _____ **Date** _____

Address _____

Telephone Number _____

Return to: Office of Student Life
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