Required Health Information
and
Forms for all Students

Failure to complete all required forms and immunizations will prohibit you from registering for classes or attending clinical rotation

Please return Health Records to:
Jefferson College of Health Sciences
101 Elm Avenue SE
Roanoke, VA 24013-2222
Attention: Student Affairs/Health Records (4th Floor CRCH)

Phone 540-985-8501
Fax 540-985-8001

Rev. 11/1/13
JEFFERSON HEALTH FORMS - CHECKOFF SHEET

Below is a checklist to help you in organizing your required Health Record documentation.

All students are required to submit the following documentation:

- **Report of Medical History Form** (completed by student)
- **Physical Exam Form** (MUST BE on Jefferson College form AND signed by Physician, Physician Assistant, or Nurse Practitioner)
- **Jefferson Immunization Record Form** (MUST BE on Jefferson College form AND signed by Physician, Physician Assistant, or Nurse Practitioner)
  - Tdap within the last 10 years
  - MMR (measles, mumps, rubella) – 2 dose series or titer showing immunity
  - PPD - required annually (must include date given, date read, and results)
  - Polio - verified case, record of childhood vaccination (strongly preferred), titer, or physician's note stating the following: “Patient is not a candidate for a booster at this time.”
  - Hep B - 3 dose series or titer showing immunity
  - Chicken Pox - verified case, 2 dose series, or titer showing immunity
  - Meningitis - **Required for Dorm Students**; recommended for all students
- **Continued Responsibility Statement** (signed by student)
- **Emergency Contact** (completed by student)
- **Health Insurance** (submit copy of front and back of ID card)
  - Recommended for all students
  - Required for ALL students entering a CLINICAL semester.
- **Medical Consent Form For Minors** (signed by student if under 18 years of age)

**STUDENTS ARE ENCOURAGED TO MAINTAIN COPIES OF ALL DOCUMENTS SUBMITTED AS IMMUNIZATION RECORDS MAY BE REQUIRED FOR EMPLOYMENT AFTER GRADUATION.**
REPORT OF PERSONAL MEDICAL HISTORY

(check if you have had any of the following)

- Anemia
- Arthritis
- Asthma
- Alcohol Abuse
- Back Problem
- Cancer
- Chronic Fatigue
- Convulsion
- Diabetes
- Eating Disorder
- Emphysema
- Epilepsy
- Fainting Spells
- Muscle Disorder
- Frequent Cough
- Glasses/Contact Lens
- Head Injury/Concussion
- Hearing Aid(s)
- Heart Problem/Murmur
- Hepatitis
- High Blood Pressure
- Infectious Mononucleosis
- Kidney Problems
- Lyme Disease
- Malaria
- Meningitis
- Migraine/Frequent Severe Headaches
- Night Sweating
- Recent Weight Gain or Loss
- Rheumatic Fever
- Sinusitis
- Skin Disorder
- Substance Abuse
- Tonsillitis (Chronic)
- Tuberculosis
- Ulcer
- Unexplained Aches & Pains
- Use Smokeless/Chewing tobacco
- Smoke Cigarettes, Cigars, or Pipe
- How many years
- How many a day

Other medical or psychological conditions that you believe we should be aware of? (Please explain)
_____________________________________________________________________________________
_____________________________________________________________________________________
List an allergies ________________________________________________________________

Have you ever been hospitalized? Had any operations? (Please note details) ________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
List all current medications _____________________________________________________________
List any serious injury _________________________________________________________________

FAMILY HISTORY

<table>
<thead>
<tr>
<th></th>
<th>AGE</th>
<th>STATE OF HEALTH</th>
<th>OCCUPATION</th>
<th>AGE OF DEATH</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Has any of your immediate family ever had any of the following? (Please state relationship)

- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Kidney Problems
- Tuberculosis
- Other

I hereby certify that the information submitted on this record is complete and correct.

Student Name – Printed LEGIBLY             Date

Student Signature                       Date
A physical examination is required and must be completed and signed by appropriate personnel.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth (month/day/year)</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

Permanent Address | City | State | Zip Code | Area Code/Phone Number |
|------------------|------|-------|----------|------------------------|

Height | Weight | BP | IF REQUIRED: Semester of Entry | Fall | Spring | Summer | Yr. |
|-------|--------|----|-------------------------------|------|--------|--------|-----|

Social Security Number | Semester of Entry | Fall | Spring | Summer | Yr. |
|------------------------|-------------------|------|--------|--------|-----|

IF REQUIRED: Semester of Entry | Fall | Spring | Summer | Yr. |
|-----------------------------|------|--------|--------|-----|

Program of Study: |

<table>
<thead>
<tr>
<th>Vision: Corrected</th>
<th>Right 20/</th>
<th>Left 20/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncorrected</td>
<td>Right 20/</td>
<td>Left 20/</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing:</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>(gross)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 ft.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are there abnormalities? | Normal | Abnormal | DESCRIPTION (attach additional sheets if necessary) |
|------------------------|--------|----------|---------------------------------------------------|

1. Head, Ears, Nose, Throat |
2. Eyes |
3. Respiratory |
4. Cardiovascular |
5. Gastrointestinal |
6. Hernia |
7. Genitourinary |
8. Musculoskeletal |
9. Metabolic/Endocrine |
10. Neuropsychiatric |
11. Skin |
12. Mammary |

A. Is there loss or seriously impaired function of any paired organs? Yes | No |
Explain |

B. Is student under treatment for any medical or emotional condition? Yes | No |
Explain |

C. Recommendation for physical activity (clinical experiences, intramurals, etc.) Unlimited | Limited |
Explain |

D. Is student physically and emotionally healthy? Yes | No |
Explain |

E. Other medical or psychological conditions that you believe we should be aware of? |

Based on my assessment of this student’s physical and emotional health on ________, he/she appears able to participate in the activities of a health profession in a clinical setting. (Date) Yes | No |

If no, please explain |

Signature of Physician/Physician Assistant/ Nurse Practitioner |

Print name of Physician/Physician Assistant/ Nurse Practitioner | Area Code/Phone Number |

Office Address | City | State | Zip Code |
|---------------|------|-------|---------|
## JEFFERSON COLLEGE OF HEALTH SCIENCES
### STUDENT IMMUNIZATION RECORD

This form is mandatory and must be signed by a Doctor, Physician Assistant, or Nurse Practitioner.

| Name: ______________________________________________________________________ |
| Last          First                                      Middle |

### Tetanus/Diphtheria/Pertussis – Tdap required every 10 years  
Tdap date __________

### Measles, Mumps, Rubella (MMR)

| Dose 1 ________  | or  | Titer Date __________  | (Attach Titer Copy) |
| Dose 2 ________  |     |                          |                      |

**Required for all students**

### PPD Test – Required annually for all students (2-step required if no PPD in last 12 months)

#### Tuberculin Skin Test

| 1-step: Date Given: _______  | Date Read _______  | Negative □  | Positive □ |
| 2-step: 1st Date Given: _______  | Date Read _______  | Negative □  | Positive □ |
| 2nd Date Given: _______  | Date Read _______  | Negative □  | Positive □ |

**OR**

### QuantiFERON TB Gold Test

| Date Given: _______  | Negative □  | Positive □ |

If PPD is positive, attach Chest X-Ray Report

Report Attached? Yes ______

### Polio  
**Required for all students**

| Dose 1 ________  | Dose 2 ________  | or  | Titer Date __________  | (Attach titer copy showing immunity) |
| Dose 3 ________  | Dose 4 ________  |     |                          |                      |

### Hepatitis B

| Dose 1 ________  | or  | Titer Date __________  | (Attach titer copy showing immunity) |
| Dose 2 ________  |     |                          |                      |
| Dose 3 ________  |     |                          |                      |

**Required for all students**

### Varicella (Chicken Pox)  
**Required for all students; PA students require a Titer**

| Dose 1 ________  | Verified  | or  | Titer Date __________  | (Attach titer copy showing immunity) |
| Dose 2 ________  | Case Date _______  |     |                          |                      |

### Bacterial Meningitis – **Required for all residence students; recommended for all students**

| Dose _________  |

**Physician, PA, or NP Name, Address, Phone Number and Signature (Required)**

Name ______________________________________________________________________  
Date ________________

Signature ___________________________________________________________________  
Phone ________________

Address ____________________________________________________________________

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## Immunization Requirements

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tetanus/Diptheria/Pertussis (Tdap)</strong></td>
<td>Documentation of Tdap within 10 years.</td>
</tr>
<tr>
<td><strong>Measles, Mumps, Rubella (MMR)</strong></td>
<td>Dose 1 – given at age 12-15 months or later. Dose 2 – given at age 4-6 years or later, and at least one month after first dose.</td>
</tr>
<tr>
<td><strong>Tuberculosis (PPD) Test</strong></td>
<td>Must be completed annually. If you have had a PPD in the last 12 months, proof of that. If you have not had a PPD in the last 12 months, your 1st PPD must be a 2-step process.</td>
</tr>
<tr>
<td><strong>Polio</strong></td>
<td>OPV alone Oral Sabin – 3 doses IPV/OPV sequential – 4 doses IPV alone injected Salk – 4 doses</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Three doses of the HPB vaccine or a positive Hepatitis antibody titer meets the requirement. If you have to get the three doses, the 2nd must be within 1-2 months after the first and the 3rd must be within 6-12 months after the 2nd. Exceptions are possible. Please check with your Health Records Specialist.</td>
</tr>
<tr>
<td><strong>Varicella</strong></td>
<td>• A verified history of chicken pox (provide note from parent stating what age student contracted the disease) or • A positive Varicella antibody from a drawn titer, or • Two doses of vaccine given at least one month apart.</td>
</tr>
<tr>
<td><strong>Bacterial Meningitis</strong></td>
<td>Required for all students living in Residence Hall. Recommended for all students.</td>
</tr>
</tbody>
</table>
CONTINUED RESPONSIBILITY STATEMENT

1) I understand that it is my responsibility to keep immunizations and TB skin tests current.

2) I agree to inform clinical instructors or the department head of any illness or health problem that could possibly affect my performance or the welfare of my patients in the clinical area.

3) I understand that if I am in a clinical rotation I am to have current health and accident insurance during each academic semester. I will maintain this coverage throughout the entire year.

4) I understand that I am to have a current CPR card in a clinical semester.

5) I attest that I have never been disbarred from and am not currently under investigation by a health (nursing/medicine, etc.) state licensure board.

6) I understand that I need to inform the College if I become aware that I am under investigation or if I am convicted of a criminal charge.

7) I understand that disclosure of the above is necessary to protect my health and the well-being of patients for whom I may provide care.

I have read the above and agree to act accordingly.

_________________________________                             ________________
Student’s Printed (legible) Name                             Date

_________________________________
Student’s Signature
EMERGENCY CONTACT INFORMATION

PLEASE PRINT CLEARLY

Student’s Printed Name ____________________________________________________________

Address: ________________________________________________

                                Street #       City       State       Zip

Phone: ____________________________       Cell Phone: __________________________

Program of Study: ______________________       Advisor: ________________________

Primary Care Physician’s Name and Phone Number: ______________________________________

(Name)       (Phone Number)

Emergency Contact #1

Name: ____________________________       Relationship to Student __________________

Address: ________________________________________________

                                Street #       City       State       Zip

Phone #1: ____________________________       Phone #2 ____________________________

Please circle one: Home       Work       Cell       Please circle one: Home       Work       Cell

Emergency Contact #2

Name: ____________________________       Relationship to Student __________________

Address: ________________________________________________

                                Street #       City       State       Zip

Phone #1: ____________________________       Phone #2 ____________________________

Please circle one: Home       Work       Cell       Please circle one: Home       Work       Cell
HEALTH INSURANCE INFORMATION

All Jefferson students are encouraged to have health insurance coverage.

Students in clinical semesters ARE REQUIRED to have health insurance coverage.

Students in clinical semesters who do not return this form prior to the beginning of their clinical semester WILL NOT be allowed to attend their clinical experience.

Medicaid coverage will be accepted with appropriate benefit card.

I understand that I am legally responsible for any medical expenses incurred during my enrollment at Jefferson and neither the College nor any clinical site will be responsible for my medical expenses.

Student’s Printed (legible) Name: _______________________ Social Security Number: _______________

Insurance Company Name: ______________________________________________________________________

Policy Number: __________________________________ Group Number: ____________________________

Subscriber Name: ____________________________________________________________________________

Signature: __________________________________________ Date: _________________________________

Student should sign if over 18 years of age.
Parents should sign if student is under 18 years of age.

ATTACH A COPY OF YOUR CURRENT INSURANCE CARD, FRONT, AND BACK TO THIS FORM.

Please attach a copy of the front of your insurance card here.

Please attach a copy of the back of your insurance card here.
MEDICAL CONSENT FORM FOR MINORS (Under Age 18)

IF THIS FORM IS APPLICABLE, PLEASE SUBMIT TO JEFFERSON PRIOR TO THE BEGINNING OF CLASSES.

Dear Parent or Legal Guardian:

The purpose of this consent form is to obtain permission from the parent or legal guardian for Jefferson College of Health Sciences to seek treatment for a student who is under the age of 18 and therefore legally a minor.

Jefferson College of Health Sciences has my permission to seek treatment for my child (print name of child legibly) in the event of a medical emergency. I understand that the College will make every effort to contact me before seeking this treatment if possible. I realize that Virginia State Law and professional codes of ethics may limit my access to confidential medical information regarding the treatment of my child.

Name of Student ___________________________ Student’s Social Security Number ___________________________

Name of Parent/Guardian (print) ___________________________ Relationship ___________________________

Signature ___________________________ Date ___________________________

Street Address ___________________________ Home Phone (please include area code) ___________________________

City, State, Zip ___________________________ Work Phone (please include area code) ___________________________

Cell Phone (please include area code) ___________________________