



Jefferson College
of Health Sciences
at CARLION CLINIC 

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: Tracy Jones
Student Affairs/Health Records (4th Floor CRCH)

Phone: 540-985-8501
Fax: 540-985-8001
Email: tljones1@jchs.edu

**Health Records are due AUGUST 1 for Fall Students
and JANUARY 1 for Spring Students**

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). Must be current – within 12 months of beginning class.
- 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
 - **Tuberculosis** - Quantiferon Gold blood test or 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 (required for PA students; must also have documentation)
 - **Meningitis** - **Required for Dorm Students**; recommended for all students
 - **Influenza** – Recommended for all students each season. Clinical sites may require.
- 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)

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

Other medical or psychological conditions that you believe we should be aware of? (Please explain)

List all allergies _____

Have you ever been hospitalized? Had any operations? (Please note details) _____

List all current medications _____

List any serious injury _____

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
Father					
Mother					
Brother(s)					
Sister(s)					

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

PHYSICAL EXAMINATION FORM

JEFFERSON COLLEGE OF HEALTH SCIENCES

**A physical examination is required and must be completed and signed by appropriate personnel
It must be current – within 12 months of starting classes**

Last Name	First Name	Middle Name	Date of Birth (month/day/year)	Social Security Number
Permanent Address			City	State
			Zip Code	Area Code/Phone Number
Height	Weight			BP /
IF REQUIRED:			Semester of Entry	Fall Spring Summer Yr.
Vision:	Corrected	Right 20/ _____	Left 20/ _____	Program of Study:
	Uncorrected	Right 20/ _____	Left 20/ _____	
Hearing:	(gross)	Right _____	Left _____	
	15 ft.	Right _____	Left _____	
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

Date

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
Healthcare Professional (MD, PA, NP, Nurse, etc.).**

Name: _____
Last First Middle

Tetanus/Diphtheria/Pertussis – Tdap required every 10 years Tdap date _____	
Measles, Mumps, Rubella (MMR) Required for all students	
Dose 1 _____ or Titer Date _____ (Attach Titer Copy)	
Dose 2 _____	
Tuberculosis – Required annually for all students (IF PPD, 2-step required if no PPD in last 15 months)	
<u>Tuberculin Skin Test</u>	
1-step: Date Given: _____ Date Read _____ Negative <input type="checkbox"/> Positive <input type="checkbox"/>	
(attach documentation for previous PPD results)	
2-step: 1 st Date Given: _____ Date Read _____ Negative <input type="checkbox"/> Positive <input type="checkbox"/>	
2 nd Date Given: _____ Date Read _____ Negative <input type="checkbox"/> Positive <input type="checkbox"/>	
OR	
<u>QuantiFERON TB Gold Test</u> Date Given: _____ Negative <input type="checkbox"/> Positive <input type="checkbox"/>	
<u>If PPD is positive, attach Chest X-Ray Report</u> (Chest X-rays are good for 5 years.)	
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 _____	
Case Date _____ or Titer Date _____ (Attach titer copy showing immunity)	
Dose 2 _____	
Bacterial Meningitis – Required for resident students; recommended for all students	
Date _____ Exp Date _____	
Influenza Vaccination – Recommended for all students (each season)	
Date _____ (attach documentation)	

Healthcare Professional Name, Address, Phone Number and Signature (Required)

Name _____ Date _____

Signature _____ Phone _____

Address _____

Immunization Requirements

Tetanus-Diphtheria	Primary series with DTaP or DTP and booster with Td in the last ten years meets requirement.
Measles, Mumps, Rubella (MMR) 2 doses required	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.
Tuberculosis must be completed annually	<p>Quantiferon gold blood test or PPD: Completed every 12 months – screening does not count – must have negative blood or scratch test. If scratch test is done (PPD) a 2-step PPD is REQUIRED if you have not had a PPD in the last 5 months.</p> <p>If you have had a PPD in the last 15 months, results from past PPDs must be submitted as well as the most recent PPD.</p> <p>If a student shows signs or symptoms of active tuberculosis disease you must proceed with additional evaluation to exclude active tuberculosis disease including tuberculin testing, chest X ray, and sputum evaluation. Negative chest x-rays are valid for 5 years.</p>
Polio – OPV alone Oral Sabin – 3 doses IPV/OPV sequential – 4 doses IPV alone injected Salk – 4 doses	Primary series in childhood meets requirements; three primary series schedules are acceptable.
Hepatitis B	Three doses of vaccine or two doses of adult vaccine in adolescents 11 – 15 years of age or a positive Hepatitis antibody meets the requirement.
Varicella	<p>Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after the age of 13 or older meets the requirement.</p> <p>History of Chicken Pox - A letter from the student's parent listing history of chicken pox, dated and signed will meet the requirement.</p>
Bacterial Meningitis – 1 dose	Required for all students living in residence hall. Recommended for all students.
Influenza – Each season	Recommended for all students each season. Many clinical sites require.

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

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)