Jefferson College of Health Sciences at Carilion Clinic

Required Health Information and Forms for all Students

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

<u>Please return Health Records to:</u>

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 (required for PA students; must also have documentation)
    - **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/how many _____ lbs.
- ❑ 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

	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

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:

Vision: Corrected Right 20/_____ Left 20/_____
Uncorrected Right 20/_____ Left 20/_____

Hearing: (gross) Right _____ Left _____
15 ft. Right _____ Left _____

Semester of Entry ___Fall___Spring___Summer___Yr.
Program of Study:

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 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
Case Date _____ **or** Titer Date _____ **(Attach titer copy showing immunity)**
Dose 2 _____

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 _____

Immunization Requirements

Tetanus/Diptheria/Pertussis (Tdap)	Documentation of Tdap within 10 years.
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 (PPD) Test	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.
Polio	OPV alone Oral Sabin – 3 doses IPV/OPV sequential – 4 doses IPV alone injected Salk – 4 doses
Hepatitis B	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.
Varicella ***A positive titer is required for all Physician Assistant Students**	• 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.
Bacterial Meningitis	**Required for all students living in Residence Hall**. Recommended for all students.

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)	