



Enclosed is a copy of your Health Record and Health Evaluation/Immunization form. This form should be completed by you and your primary care provider.

We are obligated to provide this information to you in accordance with Centers for Disease Control guidelines (www.cdc.gov). It is general information that is very pertinent and deserves your full attention. Please read each section carefully. If you have questions, please call the University Health Center Health Information office at (540) 568-6178.

Please note that if this completed Health Record is not returned to the Health Center by July 15, 2009, for fall 2009 enrollees and by Dec. 15 for spring 2010 enrollees, you will be subject to a non-refundable late fee of \$100 and a registration hold on your account.

Thank you for your attention regarding this information. We look forward to serving you during your academic career at James Madison University!

Sincerely,

A handwritten signature in black ink, appearing to read 'Cannie Campbell'.

Cannie Graham Campbell
Director, University Health Center

Health Record

Students, complete this page in full and sign where indicated.



University Health Center
MSC 7901
800 S. Main St.
Harrisonburg, VA 22807
Phone: (540) 568-6178
www.jmu.edu/healthctr

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All answers must be indicated on this form before it is considered complete. Incomplete forms will be returned.

JMU's University Health Center must have a completed and signed Health Record and Immunization Certification form on file for all eligible students before you register for classes. Complete and sign the Health Record and have your primary health care provider complete the Immunization Certification, and send it by mail to University Health Center, James Madison University, MSC 7901, Harrisonburg, VA 22807. This information is necessary to provide proper care at the University Health Center should treatment be necessary. If you are an incoming JMU student, you must also enter your Emergency Contact Information on E-campus. This information is confidential and will not be released without your consent.

Name (print) _____ Age _____ Date of Birth ____/____/____
LAST FIRST MIDDLE

Student ID# _____ Male Female Single Married Height _____ Weight (lbs.) _____

Please check your admission status: Freshman Graduate Other
Semester entering: Date _____ Transfer Re-entry Explain _____

Parents/Guardians Names _____

Home Address _____
STREET CITY STATE ZIP CODE

Home Phone (_____) _____ Business Phone (_____) _____ Cell Phone (_____) _____

EMERGENCY CONTACT INFO: (If different than parents/guardians contact information)

Emergency Contact Name _____ Relationship _____

Address _____
STREET CITY STATE ZIP CODE

Home Phone (_____) _____ Business Phone (_____) _____ Cell Phone (_____) _____

STUDENT'S HEALTH HISTORY

Check any conditions that apply if you have (or have had in the past) these problems. Provide details of positive answers below.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Kidney infection or stone | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye disorder | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Mental health | <input type="checkbox"/> Stomach disorder |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Menstrual Disorders | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Cancer (leukemia, Hodgkin's disease, other) | <input type="checkbox"/> Hepatitis or liver disease | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Colon disorder | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Organ transplant | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Pneumonia | |
| | <input type="checkbox"/> Infectious Mononucleosis | <input type="checkbox"/> Rheumatoid arthritis | |

Previous surgery(s): _____

Other: _____

Details: _____

ALLERGIES Medications, Foods, Pollen, etc. (include reaction) _____

Check here if you wish information regarding allergy injections or visit www.jmu.edu/healthctr.

MEDICATIONS

List medications (including birth control, acne drugs, antidepressants, etc.) you are currently taking (include medication/dosage and reason for taking them).

Drug _____ Dose _____ Reason _____

Drug _____ Dose _____ Reason _____

If you are currently taking medication for a chronic illness, please arrange for prescription refills from your health care provider.

FAMILY HISTORY

Check any that apply if condition exists in your extended family (immediate family, grandparents, aunts, uncles, cousins)

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye disorders | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> None |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |

TO BE SIGNED BY STUDENT

If it becomes necessary to use the facilities of the University Health Center, I hereby give permission for emergency operation or emergency medical treatment which the attending physician considers necessary. This permission relates to an emergency in which the parent or guardian cannot be contacted for explicit permission for emergency treatment without serious danger to the student. This is effective until graduation from James Madison University.

Student's Signature _____ Date _____

Please retain a copy for your record.

This form will be destroyed 10 years after I leave James Madison University. In this regard I have retained a copy of this form for my records. **It is the student's responsibility to return the original completed form by July 15, 2009**, for fall semester, **and by Dec. 15, 2009**, for spring semester to: University Health Center, James Madison University, MSC 7901, 800 S. Main St., Harrisonburg, VA 22807. Phone (540) 568-6178.

UHC use only	
Graded	
Scanned	
IMM	
Semester Entering	

Immunization Certification

To be completed and signed by licensed health care provider – Form due July 15, 2009, for fall enrollees and Dec. 15, 2009, for spring 2010 enrollees

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The Code of Virginia Section 23-7.5 requires students attending four-year public institutions to provide documentation of their immunizations by a licensed health care professional. If you are unable to provide appropriate documentation, vaccines may be repeated. Any attached documents in a language other than English **must be translated** into English by the health care provider. This information is strictly for the use of the University Health Center and will not be released without student consent. **This form will be destroyed 10 years after the student leaves James Madison University. Please retain a copy for your file.**

Name (print) _____
LAST FIRST MIDDLE
 Student ID# _____ Date of Birth _____

Fulfill immunization requirements now to prevent a registration hold. You may send a copy of the following immunizations instead of filling out this form.

IMMUNIZATIONS

Immunizations	Dates administered
Ⓡ = Required immunizations	
Ⓡ Tetanus-Diphtheria-Pertussis (All dates must be filled in) (Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last 10 years) 1. Primary series of four doses with PTaP, DTP, DP, or Td: #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ 2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient. ___/___/___ OR 3. Booster: Td within the last 10 years ___/___/___	
Ⓡ Hepatitis B 1. Immunization (Hepatitis B) a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___ OR 2. Immunization (Combined Hepatitis A and B vaccine) a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___ OR 3. Hepatitis B surface antibody Date ___/___/___ Results: Reactive ___ Non-Reactive ___	
Ⓡ Measles, mumps, rubella (MMR) After first birthday, before kindergarten or first grade. OR	#1 ___/___/___ #2 ___/___/___
Ⓡ Measles (Rubeola) Two doses vaccine required, after first birthday and 1967.	#1 ___/___/___ #2 ___/___/___ Serological confirmation of immunity. Attach copy of lab result. Date of Disease ___/___/___
Ⓡ Mumps Required after first birthday and 1967.	___/___/___ Serological confirmation of immunity. Attach copy of lab result. Date of Disease ___/___/___
Ⓡ Rubella Required after first birthday and 1967.	___/___/___ Serological confirmation of immunity. Attach copy of lab result.
Ⓡ Meningococcal vaccine	Date of Immunization ___/___/___
Ⓡ Polio	has received ___ doses, last dose given ___/___/___
Ⓡ Varicella (Chicken Pox)	#1 ___/___/___ #2 ___/___/___ OR Serological confirmation of immunity. Attach copy of lab result. OR Date of Disease ___/___/___
Ⓡ HPV (Human Papillomavirus)	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___
Ⓡ	
Signature of Health Care Provider _____	Date _____
Phone (_____) _____	

Medical Exemption

___DPT ___Td ___Measles ___Rubella ___Mumps ___TST

As specified in Section 22.1-271.2.C.(ii) of the Code, I certify that administration of the vaccine(s) designated above would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because: This contraindication is ___permanent (or) ___temporary and expected to preclude immunization until ___/___/___.

Signature of Physician or Health Department Official _____

For signature of parents

(Recommended only if student is 17 years old or younger at time of enrollment)

The law requires that parental permission be obtained in order to provide medical care to minors. This consent form should be signed by the parents so that such procedures may be carried out promptly without necessary delays. I hereby authorize the physicians, clinicians and staff nurses at JMU Student health center to examine, interview, test and, if necessary, treat my son/daughter as they deem advisable.

Signature of Parent or Guardian _____

Date _____

Tuberculosis Screening

To be completed by health care provider



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Tuberculosis screening is required of all students entering James Madison University, based upon guidelines of the American College Health Association and the U.S. Centers for Disease Control. For more information, see www.acha.org or www.cdc.gov/tb.

Name (print) _____ Date of Birth _____/_____/_____

Date completed _____ Student ID No. _____

1. Does the student have signs or symptoms of active tuberculosis disease? Y [] N []

- Unexplained elevation of temperature for more than one week, weight loss, night sweats, persistent cough for more than three weeks
- Cough with production of bloody sputum (hemoptysis)

2. Has the student ever had a positive Tuberculin Skin Test (TST, formerly PPD) or Quanti-FERON Tb test? Y [] N []

3. Is the student a member of a high-risk group? Y [] N []

- Had close contact with a known case of active tuberculosis
- Use of illegal injected drugs
- Currently on immunosuppressive therapy
- Resident or employee of a nursing home, homeless shelter or correctional facility
- Medical condition associated with increased risk of progressing to TB disease

4. Is the student foreign-born from (or traveled* to/in) a high-prevalence area? Y [] N []

- High-prevalence areas include all countries OTHER THAN Albania; American Samoa; Andorra; Antigua ad Barbuda; Australia; Austria; Barbados; Belgium; Bermuda; British Virgin Islands; Canada; Cayman Islands; Chile; Cook Island; Costa Rica; Cuba; Cyprus; Czech Republic; Denmark; Dominica; Finland; France; Germany; Greece; Grenada; Hungary; Iceland; Ireland; Israel; Italy; Jamaica, Jordan, Lebanon, Libyan Arab Jamahiriya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Puerto Rico, Saint Kitts & Nevis, Saint Lucia, Samoa, San Marino, Slovakia, Slovenia, Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, United Kingdom, U.S., U.S. Virgin Islands

* The significance of the travel exposure should be discussed by the health-care provider and the student and evaluated for risk

If the answer to all above questions is NO, no further testing or action is required.

If the answer to any question above is YES, the student must undergo Tuberculin Skin Testing, Quanti-FERON Tb testing, and/or Chest X-ray as indicated, documented below:

Tuberculin Skin Test (placed on or after March 1, 2009):

Date placed _____ Date read _____ Results _____ mm

Quanti-FERON Test (performed on or after March 1, 2009):

Results: Positive [] Negative []

Chest x-ray (required if current or previous TST or QFT test is positive):

Date _____ Normal [] Abnormal []

INH Treatment: Initiate Date _____ X _____ months Declined []

Health Care Provider:

Name _____ Phone Number _____

Address _____

Signature _____ Date _____