



James Madison University Health Record

COMMONWEALTH OF VIRGINIA LAW REQUIRES THAT THE HEALTH RECORD FORM AND CERTIFICATE OF IMMUNIZATION BE COMPLETED AND SUBMITTED TO THE UNIVERSITY HEALTH CENTER PRIOR TO ENROLLMENT AT JAMES MADISON UNIVERSITY.

This completed form must be returned by July 1 for Fall semester and December 16th for Spring semester

Send directly to: University Health Center, 235 Cantrell Ave MSC 7901, Harrisonburg VA 22807

Personal Information

Name _____
Last First Middle

Date of Birth ____ / ____ / ____ Sex _____ Student ID# _____
Mo Day Year (Student ID # is Required to Process this form.)

Home Address _____ Student Cell # (____) _____

City State Zip Code Email _____

In Case of Emergency, Notify _____ (____) _____
Name Telephone Relationship

Second Option to Notify _____ (____) _____
Name Telephone Relationship

(Please Attach A Copy of Your Insurance Card, Front and Back)

Medical History (Confidential)

1. Name any chronic illness or major medical condition for which you are being treated. Please also list any hospitalizations.

2. List medications you are currently taking _____

3. List any medicine, food, or environmental substance to which you are ALLERGIC and describe allergic reaction.

Over 18: I, hereby, give the University Health Center permission to request supporting documentation for required immunizations and treat me as they deem necessary when I present myself to the University Health Center and/or to referred specialist.

Student's Signature Date

Under 18: I, the parent/guardian of _____ hereby authorize and give permission to the University Health Center to request supporting documentation for required immunizations and treat my child whenever my child presents themselves to the Health Center and/or to referred specialist.

Print Student's Name

Signature of Parent/Guardian Date

CERTIFICATE OF IMMUNIZATION*

This MUST be signed by a health care provider.

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

Date completed ____/____/____ **Student ID No.** _____

Commonwealth of Virginia Law and James Madison University require all students to submit a health record with documented immunizations.

All immunizations must be current. In case of an incomplete immunization record, preregistration for the following semester will be blocked.

REQUIRED IMMUNIZATIONS				
DIPHTHERIA TETANUS (Within last 10 years)	Td	____/____/____ <small>Mo Day Yr</small>	OR	Tdap ____/____/____ <small>Mo Day Yr</small>
HEPATITIS B <small>(For combined Hep. A + B, do not use this line. Instead, check here: ____ and complete the appropriate line in "Recommended but Not Required")</small>	Indicate: 2-dose____ or 3-dose____ series	1) ____/____/____ <small>Mo Day Yr</small>	2) ____/____/____ <small>Mo Day Yr</small>	3) ____/____/____ <small>Mo Day Yr</small>
MENINGOCOCCAL VACCINE (Not Required for graduate students)	____/____/____ <small>Mo Day Yr</small>			
MEASLES, MUMPS, RUBELLA (MMR) <small>Students born before 1957 are not required to have a second MMR vaccination</small>	1) ____/____/____ <small>Mo Day Yr</small>	2) ____/____/____ <small>Mo Day Yr</small>	OR Titer (Attach Copy)	
POLIOMYELITIS (OPV) or (IPV) (Enter Date Completed)	____/____/____ <small>Mo Day Yr</small>			
TB SCREENING OR TB TEST	Page 3 must have been completed within the last 6 months			

RECOMMENDED BUT NOT REQUIRED			
HPV, Quadrivalent or Bivalent	1) ____/____/____ <small>Mo Day Yr</small>	2) ____/____/____ <small>Mo Day Yr</small>	3) ____/____/____ <small>Mo Day Yr</small>
HEPATITIS A	1) ____/____/____ <small>Mo Day Yr</small>	2) ____/____/____ <small>Mo Day Yr</small>	
COMBINED HEPATITIS A + B VACCINE <small>Hepatitis B is required. See above.</small>	1) ____/____/____ <small>Mo Day Yr</small>	2) ____/____/____ <small>Mo Day Yr</small>	3) ____/____/____ <small>Mo Day Yr</small>
VARICELLA <input type="checkbox"/> Had Disease <small>(two doses one month apart for adults with no history of disease)</small>	1) ____/____/____ <small>Mo Day Yr</small>	2) ____/____/____ <small>Mo Day Yr</small>	OR Titer (Attach Copy)

HEALTH CARE PROVIDER SIGNATURE	*This form will not be accepted if not signed by a health care provider
Printed Name _____ Phone _____	
Address _____	
Signature _____ Date _____	

Health care provider stamp below (if available)

JMU Health Center Staff only

Reviewed: _____

Reviewed By: _____

Notified: Compliant

Non-Compliant

Tuberculosis Screening

TB screening must be performed within the last six months.

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. _____

Section I

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, Hospital or correctional facility
4. Has the student lived or traveled in countries where Tb is endemic? **Y [] N []** Includes students who have arrived in the U.S. the past five years from countries OTHER THAN Albania, Andorra, Antigua and Barbuda, Australia, Austria, Bahamas, Barbados, Belgium, British Virgin Islands, Canada, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, French Polynesia, Germany, Greece, Grenada, Hungary, Iceland, Iran (Islamic Republic of), Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mexico, Montenegro, Nauru, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Samoa, Saudi Arabia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tonga, Trinidad and Tobago, United Arab Emirates, United Kingdom, United States of America, West Bank and Gaza Strip

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

Section II (Check the appropriate box below)

- [] If the answer to all above questions is NO, no further testing is required, please complete section IV
- [] 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 in Section III

Section III (Only indicated If answered Yes in Section II)

DOCUMENTATION OF TUBERCULIN SKIN TESTING, OR QFT-G Test, AND/OR CHEST RADIOGRAPHY*

*Based on assessment criteria outlined above.

A. Tuberculin Skin Test

Date given: ____/____/____ Date read: ____/____/____ Result: _____mm
MM DD YYYY MM DD YYYY (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors) Positive Negative

B. QuantiFERON Tb Gold Test (QFT-G) Date obtained: ____/____/____ Result: Positive Negative

C. Chest X-Ray (Required if Tuberculin Skin test or QFT-G is positive.) **(Please attach a copy of the chest X-Ray report in English)**

Result (Circle One): **Positive** **Negative**

Date of chest x-ray: ____/____/____ INH Initiated Date _____X_____months INH course completed YES NO
MM DD YYYY

Section IV

HEALTH CARE PROVIDER SIGNATURE

***(This form will not be accepted if not signed by a health care provider)**

Printed Name _____ Phone _____

Address _____

Signature _____ Date _____