SHENANDOAH UNIVERSITY

Health and Insurance Requirements Form for All SU Students

Welcome to Shenandoah University!

All students attending Shenandoah University ("SU") are required to submit to the Wilkins Wellness Center ("WWC") a fully completed Health and Insurance Requirements Form (the "health form") and appropriate supporting documentation. Students in our **nursing, pharmacy or health professions schools, or in our music therapy program (collectively, the "Health Care Programs")** require immunizations and tests in addition to those required of students in other schools/programs.

Physical Examination, Immunization and Test Requirements

All incoming students must have:

- Physical examination in the past year
- Two MMR (measles, mumps & rubella) vaccinations or a positive titer (blood test to prove immunity)
- Last date of the polio series or a positive titer
- Adult Tdap (tetanus, diphtheria & pertussis) within the last 10 years regardless of last Tdap vaccination
- Meningitis ACWY
- Two or three meningitis B vaccinations (number of doses dependent on manufacturer)

Students in the Health Care Programs must have the above and the following:

- Two Varicella (chicken pox) vaccinations or a positive titer
- COVID-19 vaccination - and be up to date per CDC guidelines
- Three hepatitis B vaccinations or a positive titer
- Current influenza vaccination after August 1
- Two TB skin tests and two readings with the second test and reading 7-21 days from the first test, or QuantiFERON TB Gold test within the last year
- NOTE: Positive TB skin test from an exposure, latent TB or BCG vaccination, the radiology report for a chest X-ray within the last 12 months and Statement of Treatment Form (included) signed by a MD/DO, NP or PA. Radiological report and Statement of Treatment Form must be submitted with the health form.

All incoming Athletes:

- Sickle Cell Trait blood test

Medical or Religious Exemptions

Shenandoah University ("SU") may grant a request for a medical or religious exemption for one or more of the above requirements. Students in the Health Care Programs or any other SU program that requires clinical or experiential training, including musical therapy ("Clinical/ Experiential Programs"), should be aware that if SU grants the student's request, it cannot guarantee SU will be able to secure the clinical/experiential assignments necessary for the student to graduate with a degree, or to obtain a licensed position in their field.

See https://www.su.edu/health-wellness/wilkins-wellness-center/health-forms/request-a-vaccine-exemption for more information.

Completed Health Form and Supporting Documentation

A completed health form, with documentation confirming a student has completed a physical examination and received all required immunizations and tests (or been granted an exemption by SU), must be provided to WWC no later than **May 15** for students starting in the summer, **August 1** for students starting in the fall, and by **December 15** for students starting in the spring.

The completed health form and supporting documentation can be mailed or personally delivered but preferred delivery is electronic and uploaded to **su.studenthealthportal.com**. Please ensure your SU student ID number is on each page of the completed health form and **keep a copy of your completed health form and supporting documentation for your records.**

Insurance Requirements

All students are required to have health insurance that complies with any applicable legal requirements (e.g., Affordable Care Act of 2010) and covers students in Virginia. Insurance documentation must be submitted online upon admission, and **updated yearly, by August 1,** at **www.RCMDstudentbenefits.com.**

This page does not need to be submitted with the completed health form.

Sincerely,

The Wilkins Wellness Center
Staff wwcenter@su.edu
tel: (540) 665-4530
fax: (540) 665-5576

Please go to su.studenthealthportal.com to upload this form electronically.

1 Medical Consent & Emergency Contact Information

All students

Date _____

Major _____

SU ID# _____

Rev 2023

All students are required to have a completed health form on file with the WWC. All immunizations or tests must include complete dates for month/day/year. A copy of the immunizations or tests must be included with your submission. This form must be completed and returned by **May 15** for the summer semester, **August 1** for the fall semester, and **December 15** for the spring semester.

Submit electronic form (document upload): su.studenthealthportal.com

If delivering in person: Wilkins Wellness Center is in Racey Hall on L.P. Hill Drive

Mail to: Wilkins Wellness Center, 1460 University Drive, Winchester, Virginia 22601

Medical Consent Form/Emergency Contact Information

I hereby give permission to the WWC at SU to administer medical treatment to me, including treatment of minor illness, injuries, medical emergencies, and required or recommended immunizations. I also grant consent to SU to share any of my medical information in its possession with any emergency medical and/or medical facility personnel treating me ("Third-Party Medical Personnel") that SU deems to be in my best interest. In addition, I also grant consent to any Third-Party Medical Personnel to share any of my medical information in their possession with SU that such Third-Party Medical Personnel deems to be in my best interest. If I am a member of, or trying out for, an SU athletic team, I understand that WWC staff will discuss with the Athletics, Health Care Professionals and Counseling Center information about my health that might affect my ability to participate on an SU athletic team, clinicals or my academic program.

Student Signature: _____ Student Name (Print): _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Field of Study/Major: _____ SU Athlete (circle one): Yes or No

Graduate or Undergraduate *(circle one)* | Campus Resident or Commuter *(circle one)*

Email address: _____ Student's (cell) number: _____

SS#: _____ Date of Birth: _____

Name of emergency contact person: _____ Relationship: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile: _____

If the student is under the age of 18 years old:

I, _____ hereby represent that I am a parent with custodial rights, or the legal guardian, of the above named student and I give permission to SU to treat my child and for SU and Third Party Medical Professionals to share medical information about my child that they deem to be in the best interest of my child as further described above.

Parent/Legal Guardian Signature: _____ Date: _____

Please go to su.studenthealthportal.com to upload this form electronically.

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Immunization & Tuberculosis Test History

All students

Name: _____

_____

SU ID# _____

Date of Birth: _____

Immunization History

Record complete dates *(month/day/year)* in chart below. Form to be completed and signed by a Licensed Physician, Physician's Assistant or Nurse Practitioner. Documents proving that you had the required immunizations or titers **must** be included with your completed health form.

Immunization *The chart must be filled in or the record will not be accepted*	**Complete Date of Immunization** *month/day/year*	**Complete date of titer and results** *(Attach copy of lab report)*	**Manufacturer** *(required for COVID-19)*
Measles, Mumps, Rubella vaccine #1 or titer			N/A
Measles, Mumps, Rubella vaccine #2 or titer			N/A
Polio (last date in series only) or titer			N/A
Tetanus, Diphtheria, Pertussis (Adult) within the last 10 years		N/A	N/A
Varicella/ Chicken Pox (2 vaccination dates) or titer*** (Date of disease is not acceptable)	1)	2)	N/A
Varicella /Chicken Pox Titer and results***	N/A		N/A
Meningitis (ACWY)		N/A	N/A
Meningitis B	1)	2)	3)
Hepatitis B Series (3 dates)	1)	2)	3)
Hepatitis B Titer and results	N/A		N/A
Influenza vaccine (after August 1 for fall semester)***		N/A	N/A
COVID-19 vaccine			
COVID-19***vaccine as required by your specific program		N/A	N/A
Sickle Cell Trait Titer (Athletes only)			

*** Required for students in the **Health Care Programs**, recommended for all other students ***

Two-step tuberculosis tests: Two TB skin tests/readings. The first test/reading must be followed by a second test/reading between 7-21 days from the first test per our clinical contract. An annual test will be required thereafter. A QuantiFERON –TB Gold test can replace the two-step TB skin tests. Please upload documentation.

TB skin test (PPD/TST) #1: Date placed:_____ Date read:_____ mm (induration) _____

TB skin test (PPD/TST) #2: Date placed:_____ Date read:_____ mm (induration) _____

QuantiFERON –TB Gold/T-Spot (**attach lab report**) Date:_____ Neg:_____ Pos:_____

Chest X-Ray Results *(if positive PPD within the last 12 months)*: Date: _____ Neg: _____ Pos: _____ *(Attach radiology report)*

If you have a positive test (exposure or BCG vaccination) and a chest X-ray is ordered, the Statement of Treatment Form must be completed by your primary care provider.

Health Care Provider (Print): _____ Signature: _____

Phone: _____ Date: _____

Please go to su.studenthealthportal.com to upload this form electronically.

3 Personal Health History

All students

Name: _____

_____

SU ID# _____

Date of Birth: _____

Personal Health History

Allergies (Medication / Food / Environmental / Latex): _____

Medications taken daily or as needed: _____

Surgeries: _____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR PERSONAL HEALTH HISTORY AND EXPLAIN BELOW:

- ☐ PSYCHIATRIC DISORDER (INCLUDING ANXIETY / DEPRESSION).
- ☐ HEADACHES/MIGRAINES.
- ☐ NEUROLOGICAL DISORDER (SEIZURES, MIGRAINES)
- ☐ VISUAL DIFFICULTIES
- ☐ RESPIRATORY DISEASE (INCLUDING ASTHMA / REACTIVE AIRWAY DISEASE).
- ☐ SKIN / DERMATOLOGICAL DISORDER
- ☐ CARDIAC DISORDER / HYPERTENSION / CHOLESTEROL
- ☐ GASTROINTESTINAL DISORDER
- ☐ MALE/FEMALE ISSUES
- ☐ LIVER DISEASE (I.E., HEPATITIS)
- ☐ DIABETES
- ☐ RENAL DISEASE (KIDNEY)
- ☐ CANCER
- ☐ IMMUNE SUPPRESSED
- ☐ OTHER

Other restrictions: _____

_____

_____

_____

Explain any check marks above: _____

_____ : _____

_____

_____

Student Signature *(Parent Signature if student<18)* _____ Date: _____

Please go to su.studenthealthportal.com to upload this form electronically.

4 Physical Exam Form

All students except for Commuter students, not enrolled in a health program, and not participating in sports

Name: _____

SU ID# _____

Date of Birth: _____

Physical Exam

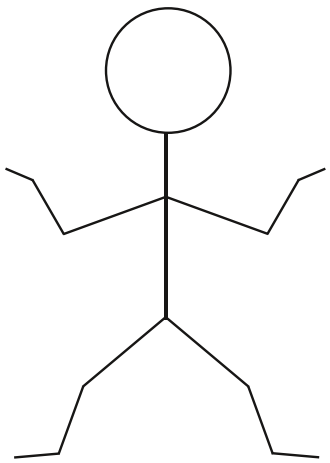
Vital Signs: Ht _____ Wt _____ BP _____ Pulse _____ Temp _____ LMP _____ BMI _____

Vision: OD _____ OS _____ OU _____ Rx Lenses *(circle one)*: Yes or No Contact Lenses *(circle one)* : Yes or No

Physical Examination	Normal	Abnormal	Notes
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary (testicles) *			Glucose _____Protein _____ Blood _____Leuk _____
Musculoskeletal			
Metabolic/Endocrine			
Derm			
Lymph			
Neuro / Psychiatric			

* Testicle exam required for men participating in sports.

Deep Tendon Reflexes:



Additional Comments: _____

Health Care Provider (Print): _____ Signature: _____

Phone: _____ Date: _____

Please go to su.studenthealthportal.com to upload this form electronically.

5 Wilkins Wellness Center Tuberculosis Risk Assessment Form

All students

Name: _____

_____

SU ID#_____

Date of Birth:_____

Required for students in schools or programs other than Health Care Programs

Please complete the following form completely. Place a checkmark in the box in front of the section if any item in the section is true for you. **IF YOU CHECK ONE OF THE BOXES IN SECTIONS 1 – 4, YOU ARE REQUIRED TO HAVE A TUBERCULOSIS (PPD) SKIN TEST.** Check the box at the bottom of the page if sections 1-4 do not apply to you. Sign and date the form at the bottom. If you are under 18 years of age, your parent or guardian will need to sign the form.

☐ **Section 1:** Check this box if you have any of the following Possible Symptoms of Tuberculosis:

- Unexplained weight loss
- Unexplained elevation of temperature for more than one week
- Unexplained night sweats
- Unexplained persistent cough for more than 3 weeks
- Unexplained cough productive of bloody sputum

☐ **Section 2:** Check this box if you have any of the following Risk Factors for Tuberculosis Infection:

- Close contact with a known case of active tuberculosis
- Use of illegal injected drugs
- HIV (Human Immunodeficiency Virus) infection
- Health Care Worker currently employed in a high-risk hospital setting
- Resident or employee in a congregate living setting (nursing home, homeless shelter, correctional facility)

☐ **Section 3:** Check this box if you have any of the following Risk Factors for Tuberculosis Disease:

- Diabetes mellitus
- Lymphoma, leukemia or cancer of the head, neck or lung - chronic kidney failure
- Silicosis
- Gastrectomy or jejuno-ileal bypass
- Long-term immunosupressive therapy
- Greater than 10% below ideal body weight

☐ **Section 4:** Check this box if you have lived in or traveled for 90 days or more to any of the following Areas with a High Prevalence of Tuberculosis as defined by the World Health Organization and the state health department:

- Africa – All countries
- Asia/Southeast Asia/Pacific Islands – All countries
- North, Central & South America – Argentina, Belize, Bolivia, Brazil, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
- Europe – Belarus, Bosnia-Herzegovina, Bulgaria, Latvia, Lithuania, Macedonia, Moldova, Portugal, Romania, Russian Federations, Serbia, Ukraine
- Middle East – Iraq, Kuwait, Qatar, Yemen

☐ No, none of the items listed in section 1 – 4 apply to me.

Student Signature *(Parent Signature if student<18)* _____ Date: _____

Wilkins Wellness Center Staff Member:_____ Date: _____

Please go to su.studenthealthportal.com to upload this form electronically.

6 Wilkins Wellness Center Tuberculosis Statement of Treatment

Positive TB Test Only

Name: _____

_____

SU ID#_____

Date of Birth:_____

If you have a positive test (exposure or BCG vaccination) and a chest X-ray is ordered, the Statement of Treatment Form must be completed by your primary care provider.

Dear Provider,

Your patient, _____ date of birth:_____will be providing direct patient care to comply with the clinical experience requirements. See attached chest x-ray documentation.

Free of Active Disease or Determined to have Latent TB

☐ My patient, named above, has been examined for Pulmonary Tuberculosis (TB) and is free of active disease. The patient has been counseled on the risk of developing Pulmonary TB and risks that the patient may pose to their contacts. The patient has been instructed on signs and symptoms of Pulmonary TB and to seek medical evaluation should they become symptomatic.

Placed on Treatment Therapy for Latent TB: No_____ Yes _____ Rx: _____

Follow-up appointment date: _____

Return to school/clinical status: **May** return to full duty as of (date):_____

Current Diagnosis of Active Disease

☐ Placed on Treatment Therapy: No _____Yes _____ Rx: _____

Follow-up appointment date:_____

Return to school/clinical status: **May not** return to school/clinical at this time due to current diagnosis of "active Tuberculosis." _____

Treatment of Active Disease

☐ I attest that I am a health care provider qualified to make the determination that this patient is no longer infectious by demonstrating sputum is free of bacilli on three (3) consecutive smears on separate days or sputum cultures show no growth.

Return to school/clinical status: **May** return to school/clinical full duty as of (date):_____

Comments: _____

_____

Provider Signature (MD/DO, NP, PA):_____ Date: _____

Health Care Provider (Print Name): _____

Phone: _____

Address: _____