HAMPDEN-SYDNEY COLLEGE

STUDENT HEALTH SERVICES

204 College Rd, Hampden-Sydney, VA 23943

NEW STUDENT HEALTH FORM

The staff at Student Health are dedicated to providing you with high-quality health care designed specifically to meet the needs of college students; however, we need your help to do our job well. It is necessary for us to have an accurate health record for each of our students; **this record must be completed and returned to Student Health by August 1.**

INSTRUCTIONS:

1. Complete pages 1, 2, and 4 yourself or with the help of your family.
2. Make an appointment for a physical examination with your health care provider. Have them fill in pages 3, 5, and 6.
3. Make a copy of your complete record for your files, then return the completed form to:

Student Health
PO Box 336, Hampden-Sydney College, Hampden-Sydney, Virginia 23943
(434) 223-6167 · FAX (434) 223-7071

RELEASE OF INFORMATION

When appropriate to ensure your health, well-being, and academic success, the Health Center may, in particular circumstances, share some of the information that you or your health care provider include on this form with the Director of Counseling, the Director of Sports Medicine or Head Athletic Trainer, the Assistant Dean of Students for Substance Abuse, and/or the Associate Dean for Academic Support.

___ I **do** give my permission for the information on this form to be shared as described above.

___ I **do not** give my permission for the information on this form to be shared as described above.

Signed ____________________ Date ____________

Student's full name ____________________ Nickname ____________

Address ____________________ Telephone ____________

City ____________________ State ____________ Zip ____________

Date of Birth ____ / ____ / ____ Circle one: Freshmen Transfer Religion (optional) ____________

IN CASE OF EMERGENCY, please notify:

Name ____________________ Relationship ____________

Address ____________________

City ____________________ State ____________ Zip ____________

Home phone ____________________ Other phone #'s ____________________

Business phone ____________________ ____________________

E-mail address ____________________ Fax # if available ____________________

EMERGENCY TREATMENT

In the case of an extreme emergency, I give permission to the Dean of Students, or his designee, of Hampden-Sydney College to sign a consent for emergency treatment when in the best judgment of medical personnel further delay would jeapardize the life or health of ____________________ . Every reasonable effort will be made to contact a family member before this authorization is used.

Student's signature ____________________ Date ____________

Parent or guardian's signature (if student is under 18 years of age) ____________________

FAMILY HISTORY

General Family Health Status: Mother ______________________ Father____________________ Siblings ___________________

If deceased, give age and cause of death ____

Which of your blood relatives have had any of the following?

High Blood pressure_________________ Diabetes_______________________________ Mental Illness ____________________
Heart Disease _____________________ Tuberculosis ____________________________ Cancer _________________________
Kidney Disease ____________________ Seizure Disorder _________________________ Stroke __________________________
Alcoholism _______________________ Other serious illnesses (please specify) ____________________________________

YOUR PERSONAL HISTORY

Have you ever been told that you have or have had any of the following? (Please circle all that apply)

ADD/ADHD
Appendicitis
Chicken Pox
Depression
Heart Problems
Suppressed immune system
Mono
Thyroid Problems
Vision problems
Alcohol or other drug problems
Asthma
Colitis or Irritable Bowel
Diabetes
Hepatitis
Kidney problems
Orthopedic problems
Tuberculosis
Anxiety Disorder
Arthritis
Concussion
Hearing Impairment
High Blood Pressure
Learning Disability
Seizure Disorder
Ulcers

Other disease or disorder ____

____

Do you now or have you ever experienced any of the following? (Please circle all that apply)

Seasonal allergies
Frequent diarrhea
Fluttering or racing heartbeat
Frequent inability to concentrate
Skin disorders
Frequent vomiting
Chest pain
Recurrent earaches
Frequent, severe headaches
Feelings of loneliness or despair
Sleepwalking
Unexplained weight loss or gain
Convulsions
Excessive thirst
Frequent head colds
Recurrent pain (where?__________)
Frequent sore throat
Head injury

HAVE YOU HAD ADVERSE (BAD) OR ALLERGIC REACTIONS TO ANY MEDICATIONS?

NO ______ YES ______ If yes, to what medication(s)? ____
____
____

OTHER ALLERGIES (list) ____

(If yes, how do you treat these allergies?)____

SURGERY AND SERIOUS ILLNESS (please explain and give dates)____

____
____
____
____

CURRENT HEALTH PROBLEMS AND MEDICATIONS THAT YOU ARE NOW TAKING (please list)

____
____
____
____

THIS PAGE MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER

Student's name ______________________________ Date of Birth____________________

Health Care Provider's name ______________________________ Phone # ____________________

Health Care Provider's address ______________________ City ______________ State ______ Zip ________

....

Height ____________ Weight __________ Blood Pressure ______________ Pulse ______________ regular/irregular

Vision ________________________ Hearing __________________________

Urinalysis (when indicated) ____

CBC (when indicated) ____

MEDICATION ALLERGIES____

PHYSICAL ASSESSMENT
(If necessary, please continue on page 4)

	Normal	Abnormal (Please explain)
Head, ears, nose, and throat	_________	_______________________________
Respiratory	_________	_______________________________
Cardiovascular	_________	_______________________________
Gastrointestinal	_________	_______________________________
Hernia	_________	_______________________________
Genitourinary	_________	_______________________________
Musculoskeletal	_________	_______________________________
Endocrine/metabolic	_________	_______________________________
Neuropsychiatric	_________	_______________________________
Skin	_________	_______________________________
Teeth	_________	_______________________________
Thyroid	_________	_______________________________
Orthopedic	_________	_______________________________
Other	_________	_______________________________

Testicular Self-Examination explained? Yes _____ No _____

TUBERCULOSIS SCREENING (when appropriate for high-risk students according to CDC guidelines)

1. PPD (Mantoux) within the past 12 months
   Result: Neg ____ Pos ____ ______mm _____/_____/_____
   Mo Day Yr
2. If PPD is positive, chest X-ray required: X-ray result: Normal / Abnormal Date _____/_____/_____

   FOLLOW-UP TREATMENT (when appropriate): ____

General comments ____

____ This student is capable of strenuous activities including varsity athletics.

____ This student needs further evaluation before participating in strenuous activities.

____ This student should not participate in strenuous activities. Please explain ______________________________

____

____

Is this student being treated at this time for any medical or emotional problems? No_____ Yes_____ (if yes, please explain)

____

Health Care Provider's signature______________________________ Date ______________

INSURANCE INFORMATION

(Please make sure that you have a personal copy of your health insurance information; that information should be as handy as your driver's license.)

You are responsible for the cost of your medical care while you are at Hampden-Sydney College. With very few exceptions, there is no charge for the services provided at the Health Center, including treatment provided by the College Physician; however, you will be responsible for all of your other medical expenses, including prescription drugs.

If your private health insurance is through a managed care plan such as an HMO, please contact that provider to ensure that you will be covered **conveniently** while you are at college. The Health Center does not routinely accept the responsibility of contacting "primary care providers" for referrals.

The Health Center **does not** file claims with any insurance carriers.

We also encourage you to plan for expenses such as prescription drugs; the cost of medications is frequently not covered by insurance plans.

Please attach a copy of your insurance information to this form (front and back).

Please notify the Health Center if your insurance changes.

I. Name of Insurance Company ______________________________

Phone #s (1)______________________ (2)______________________

Address ______________________________

If applicable, other Information from your insurance card:

Group # ______________________ Name of Policy Holder ______________________

Group where insured ______________________________

Identification # ______________________________

Additional Information ______________________________

____

STUDENTS WITH SPECIAL NEEDS

Students who have physical limitations that may require special environmental accommodations should contact the Office of Student Affairs at (434) 233-6128 and the Disability Coordinator at (434) 223-6324.

Students who have documented learning difficulties and who may need special academic considerations, should contact the Associate Dean for Academic Support at (434) 223-6324.

Student's Name ____ Date of Birth ______/______/______
Mo Day Yr

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

REQUIRED

A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later . ...#1 ____/____/________
M D Y
2. Dose 2 given at least 28 days after first dose . ...#2 ____/____/________
M D Y

B. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____/____/________
M D Y
2. Date of most recent booster dose: ____/____/________ Type of booster: Td _____ Tdap _____
M D Y

C. POLIO

2. IPV/OPV series completed ____/____/________
M D Y

STRONGLY RECOMMENDED

A. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
   a. Dose #1 ____/____/________ b. Dose #2 ____/____/________
   M D Y M D Y
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ____/____/________
M D Y

B. SEROGROUP B MENINGOCOCCAL

The vaccine series must be completed with the same vaccine.

1. MenB-RC (Bexsero) __ routine ____outbreak –related
   a. Dose #1 ____/____/________ b. Dose #2 ____/____/________
   M D Y M D Y

OR

2. MenB-FHbp (Trumenba) __routine ___outbreak-related
   a. Dose #1 ____/____/________ b. Dose #2 ____/____/________ c. Dose #3 ____/____/________
   M D Y M D Y M D Y

C. INFLUENZA

Trivalent (IIV3) _____ Quadrivalent (IIV4) _____ Recombinant (RIV4) _____ Live attenuated influenza vaccine (LAIV) _____
Adjuvanted inactivated influenza (aIIV3) _____

Date of last dose: ____/____/________
M D Y

D. HEPATITIS A

1. Immunization (hepatitis A)

a. Dose #1 ____/____/________ b. Dose #2 ____/____/________
M D Y M D Y

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ____/____/________ b. Dose #2 ____/____/________ c. Dose #3 ____/____/________
M D Y M D Y M D Y

E. HEPATITIS B

Heplisav-B (2 dose series) is not interchangeable with other hepatitis B vaccines (3 dose series) but can substituted for dose #2 and #3.

1. Immunization (hepatitis B)

a. Dose #1 ____/____/________ b. Dose #2 ____/____/________ c. Dose #3 ____/____/________
M D Y M D Y M D Y

Adult formulation ___ Child formulation ____ Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____
HepB-CpG (Heplisav-B) ____ HepB-CpG (Heplisav-B) ____ HepB-CpG (Heplisav-B) ____

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ____/____/________ b. Dose #2 ____/____/________ c. Dose #3 ____/____/________
M D Y M D Y M D Y

3. Hepatitis B surface antibody (recommended for individuals born in or whose mother was born in a hepatitis B endemic country and/or men who have sex with men; required for health science students).

Date ____/____/________ Result: Reactive ________ Non-reactive ________

F. HUMAN PAPILLOMAVIRUS VACCINE

Immunization (indicate which preparation, if known) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____ or 9-valent (HPV9) ____

a. Dose #1 ____/____/________ b. Dose #2 ____/____/________ c. Dose #3 ____/____/________
M D Y M D Y M D Y

G. VARICELLA

1. Immunization

a. Dose #1 . ...#1 ____/____/________
M D Y

b. Dose #2 given at least 12 weeks after first dose ages 1–12 years. ....#2 ____/____/________
and at least 4 weeks after first dose if age 13 years or older.
M D Y

2. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

H. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

PCV 13 _______ Date ____/____/________ PPSV 23 _______ Date ____/____/________
M D Y M D Y

HEALTH CARE PROVIDER

Name ____ Signature ____

Address ____ Phone (__________)______________________________

Hampden-Sydney College
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Hampden-Sydney, VA 23943
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