



HEALTH INFORMATION FORM

[Must be *complete* to avoid \$200 fine]

RETURN ENTIRE FORM to Lynchburg College Student Health Services, 1501 Lakeside Drive, Lynchburg, VA 24501, **DUE BY: July 31 [Fall entrance] / January 15 [Spring entrance]**

The entrance Health Information Form is required for all full time Lynchburg College students, regardless of residence. Please carefully complete the form, using *black ink*, providing accurate and honest information. This information will be used *only* by Student Health Services and will not be released without your written consent. Complete Part A (pages 1 and 2). Then take the ENTIRE form to your examining physician for completion of Parts B and C, within 6 months prior to class participation and/or collegiate practice, per NCAA bylaw 17.1.5.

PART A MEDICAL HISTORY

Last Name (please print) _____ First Name _____ Middle Name _____ Social Security Number _____

Home Address (number & street) _____ City or Town _____ State _____ Zip Code _____ Phone Number () _____

BIRTHDATE: Month _____ Day _____ Year _____ Sex: Male Female Marital Status _____

Father's Name _____ Address _____ Phone Number () _____

Mother's Name _____ Address _____ Phone Number () _____

Whom to notify in case of emergency _____ Home Phone Number () _____ Business Phone () _____

Family Physician's Name _____ Address _____ Phone Number () _____

INSURANCE

All students are *expected* to have health insurance coverage while attending Lynchburg College. The College cannot protect students from the consequences of being uninsured.

Insurance Company _____ ID/Group# _____ Individual/Employee ID# () _____

MEDICAL CONDITIONS

List all major medical conditions, surgeries, and hospitalizations. Give brief details, including dates.

MEDICATIONS

If you take any medications orally or by injection on a frequent or regular basis, list and indicate dosage and frequency.

ALLERGIES

Do you have any allergies to medications? ___ Yes ___ No Specify: _____

Other Allergies: _____

PART A MEDICAL HISTORY (continued)

PERSONAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe Anxiety/Depression | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Irritable Bowel/Spastic Colon |
| <input type="checkbox"/> Asthma/Bronchitis/Pneumonia | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Frequent Colds/Sinus Infections | <input type="checkbox"/> Sexual Assault/Abuse | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Dizzy/Fainting Spells |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Anemia/Blood Disorder/SCTrait |
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Epilepsy/Seizure Disorder |
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Back/Joint Injuries | <input type="checkbox"/> Chronic Headaches/Migraines |
| <input type="checkbox"/> Pelvic Infections/STD's | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> MRSA Infection | <input type="checkbox"/> Recurrent Bladder/Kidney Problem | <input type="checkbox"/> Other |

Details of above: _____

1. Do you have a physical disability? _____ If yes, explain any special services needed" _____
2. Have you ever had a serious illness, injury or operation not listed above? _____ Explain _____
3. Have you ever had an overnight hospital admission? _____ If yes, give date and reason _____

FAMILY HEALTH HISTORY

INDICATE ANY PRESENT OR PAST HEALTH CONDITIONS IN PARENTS OR SIBLINGS:

<u>ILLNESS</u>	<u>FAMILY MEMBER</u>	<u>ILLNESS</u>	<u>FAMILY MEMBER</u>
<input type="checkbox"/> Death before age 50	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart /BP Disease	_____	<input type="checkbox"/> Seizure/Neurological Disorder	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Anxiety/Depression	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Alcohol/Drug Problems	_____

Is anyone in your immediate family suffering from other serious health problems? _____ Explain _____

Number of siblings _____ List deceased parents and siblings with cause of death _____

PERMISSION FOR TREATMENT: THIS FORM MUST BE SIGNED AND DATED BY THE STUDENT.
 If the student is a minor (under 18 years of age), this form must also be signed by a parent or legal guardian.

I certify that the information I have provided on this form is truthful, accurate and complete to the best of my knowledge. I understand it is intended for and will be used only by Lynchburg College Student Health Services personnel and will be maintained as confidential information in my student health record. This information will not be released without my written consent, *except in cases of life threatening emergencies*. I also understand that information on this form is intended for medical services only. If I desire assistance or accommodations from non-medical offices at Lynchburg College, I understand that it is my responsibility to contact Student Support Services at (434) 544-8419.*

Signature of Student (required) _____ Date _____

Signature of parent of guardian _____ Date _____
 (required if student is under 18 years of age)

PART B IMMUNIZATION RECORD
TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

REQUIRED IMMUNIZATIONS

- A. MMR (Measles, Mumps, Rubella) Dose #1 ____/____/____
Two doses live vaccine at or after 12 months of age, at least one month apart Dose #2 ____/____/____
- B. DIPHTHERIA/PERTUSSIS/TETANUS (DPT)
 1. Primary childhood series completed ____/____/____
 2. Tetanus/Diphtheria (Td/Tdap) **Booster within last 10 years-** ____/____/____
- C. POLIO SERIES: Primary childhood series completed ____/____/____
- D. MENINGOCOCCAL VACCINE: **Booster required after age 16 -** ____/____/____
- E. HEPATITIS B VACCINE Dose #1 ____/____/____
(Series of 3 vaccines) Dose #2 ____/____/____
Dose #3 ____/____/____
Mo Day Yr
- F. TUBERCULOSIS SCREENING within last 12 months

TB Risk Assessment:

1. Does the student have signs or symptoms of active TB disease? YES NO (circle)
 Fatigue, unexplained weight loss, loss of appetite, night sweats, chronic cough, hemoptysis, chest pain
2. Is the student a member of a high-risk group? YES NO (circle)
 Plans to enter health care profession; known exposure to HIV infection; contact with person infected with TB; IV drug user; has resided or worked in homeless shelter, prison, nursing home, hospital, other health care facility; history of silicosis, diabetes, chronic renal failure, hematologic disorders, cancer, low body weight, gastric bypass, prolonged corticosteroid or other immunosuppressive therapy; or within the past 5 years traveled to or lived in any country where TB is endemic.
 (Screening guidelines and list of endemic countries available at www.lyncburg.edu/health)

If NO to all the above, student is considered low risk and no further evaluation is needed

If YES to any of the above, PPD REQUIRED.

PPD (Mantoux) (within the past 12 months)
 Result ____ mm Negative Positive (circle) Assessment/Reading Date ____/____/____

IF PPD EVER POSITIVE, CHEST X-RAY AND COPY OF REPORTS ARE REQUIRED FOR LC HEALTH FILES.

RECOMMENDED IMMUNIZATIONS

1. HEPATITIS A VACCINE Dose #1 ____/____/____
2 doses vaccine given at 0, 6-12 months Dose #2 ____/____/____
2. VARICELLA VACCINE Dose #1 ____/____/____
If no history of Chicken Pox, 2 doses vaccine at least 4 weeks apart Dose #2 ____/____/____
3. HUMAN PAPILLOMAVIRUS VACCINE (HPV) Dose #1 ____/____/____
3 doses at 0, 2, and 6 month intervals Dose #2 ____/____/____
Dose #3 ____/____/____
Mo Day Yr

***Medical Exemption _____ * Religious Exemption _____ (Letter must be submitted)**

- Transcribed records of student Gave vaccine to student

➡ Health Care Provider's Signature _____
Name Printed _____
Address _____
Phone _____

PART C PHYSICIAN'S HEALTH EVALUATION

****TO BE COMPLETED, SIGNED AND DATED BY EXAMINING PHYSICIAN, NP, or PA
Must be within 6 months prior to class participation and/or collegiate activity. ****

Note to examiner: Please review the student's medical history (Part A) and complete this form, commenting on all positive answers. This information will be used as a background for providing appropriate health care and is solely for use by Lynchburg College Student Health Services. No information will be released without the student's written consent.

Pulse _____ Blood Pressure _____ Height (in) _____ Weight (lbs) _____ Date last Td/Tdap _____

Hct/Hgb _____ Sickle Cell Screening [Hgb S] (*athletes required*) Negative/Positive trait/Positive disease- *circle one*

Tuberculosis Screening (see page 3) Risk factors present ___NO___YES If Yes, PPD documentation required.

PHYSICAL EXAMINATION

HEENT	
RESPIRATORY	
CARDIOVASCULAR	
GENITOURINARY	
GASTROINTESTINAL	
MUSCULOSKELETAL	
METABOLIC/ENDOCRINE	
NEUROLOGICAL	
SKIN	

*****PLEASE ATTACH ANY PERTINENT RECORDS (special tests, labs, etc.)**

Has the student ever been treated for an emotional, behavioral, or psychological condition (including eating disorders and/or substance abuse)? ___ No ___ Yes ***Explain _____

Is the student currently under treatment for any medical/psychological condition? ___ No ___ Yes ***Explain, including recommendations for Student Health Services' follow-up _____

Has the student ever been diagnosed with MRSA? ___ No ___ Yes/Date _____ Specific Tx _____

List any medications the student is taking. _____

➡ PERMISSION FOR CLASS PARTICIPATION (including COLLEGIATE ATHLETICS)

Must mark one of the following:

UNRESTRICTED ACTIVITY _____

RESTRICTED ACTIVITY _____ ***Explain restrictions _____

**DATE _____ (within 6 months prior to 1 st class)
**MD/NP/PA SIGNATURE _____
PRINTED LAST NAME _____
ADDRESS _____
PHONE _____ FAX _____

***Attach letter/test results as needed.

RETURN COMPLETED FORM TO:
STUDENT HEALTH SERVICES
LYNCHBURG COLLEGE
1501 LAKESIDE DRIVE
LYNCHBURG, VA 24501
FAX: 434-544-8185

FOR ATHLETES ONLY:

I hereby give permission to Student Health Services to release a copy of my Immunization Record, Sickle Cell Screening result and Physician's Health Evaluation to Lynchburg College Athletic Training per NCAA requirements.

Student's Signature _____

Date _____