PART I - STUDENT PRE-ENTRANCE HEALTH FORM

ALL students MUST complete Part I & II. Athletes & VWIL students MUST complete Parts I, II, and III.

Submit **NO LATER THAN**: **JUL 15th for Fall** or **DEC 1st for Spring** enrollment.

---------------- HOW TO SUBMIT ----------------

Quick Electronic File Upload: https://go.marybaldwin.edu/student/new/

FAX: (540) 887-7289 or **MAIL:** MBU Office of Health Services, PO Box 1500, Staunton, VA 24401.

Questions? CALL: (540) 887-7095

Save As | Print | Clear

STUDENT INFORMATION

Last Name	First Name	MI	Date of Birth (MM/DD/YY)

Student Type:	Select Programs: (Athletic/VWIL students MUST submit Section III	MBU Student ID
☐ First Year ☐ Transfer	☐ PEG ☐ Athletics ☐ VWIL (Virginia Women's Leadership Institute)	

Permanent Home Address	City	State	Zip code

Home Phone	Mobile Phone	Email Address

MEDICAL INSURANCE (Out-of-state Medicaid is NOT accepted in VA, except in a hospital ER)

Name of Insurance Company	Member ID/Group ID	Phone Number
Have you attached a copy of Insurance?	☐ YES ☐ NO (Must attach a front and back copy of Insurance Card)	

PARENT/GUARDIAN 1

Last Name	First Name	Middle Initial

Home Phone	Mobile Phone	Email Address

PARENT/GUARDIAN 2

Last Name	First Name	Middle Initial

Home Phone	Mobile Phone	Email Address

EMERGENCY CONTACT

Last Name	First Name	Middle Initial

Home Phone	Mobile Phone	Email Address

***** CERTIFICATION ****

I certify that the information provided in the entirety of this health form to be true and complete to the best of my knowledge. I also understand that the information I have provided in this health record may be reviewed by staff from the MBU Health Center, Counseling and Psychological Services, VWIL (if applicable), PEG (if applicable) and the Head Athletic Trainer, as needed. I give permission to MBU to furnish such procedures as may be deemed necessary by the Health Center, Counseling and Psychological Services and Head Athletic Trainer on my student's behalf.

SIGNATURE AUTHORIZATION (Student or Parent/Legal Guardian if under 18 years of age)

Student Signature **Name (Print)** **Date**

CONSENT FOR THE TREATMENT OF MINORS – STATEMENT MUST BE SIGNED IF STUDENT IS UNDER 18 YRS.

I hereby authorize and give permission to the Student Health Center to treat my child whenever he/she presents to the Health Center for routine medical care, vaccinations, and/or treatment for minor injuries and illnesses.

Parent/Legal Guardian Signature (if under 18yrs) **Name (Print)** **Date**

Last Name	First Name MI	Date of Birth (MM/DD/YY)

	ALLERGIES (Drug, Food, Insect)		SURGERIES & HOSPITALIZATIONS		MEDICATIONS
1		1		1	
2		2		2	
3		3		3	
4		4		4	
5		5		5	

☐ **No known allergies** ☐ **No surgeries or hospitalizations** ☐ **No Medications**

PERSONAL HEALTH HISTORY (Please select those that apply)

☐	Asthma/Reactive Airway	☐	Heart Arrhythmia	☐	Suicide Attempt
☐	Allergies (seasonal)	☐	High Blood Pressure	☐	Kidney Disease
☐	Eczema	☐	Anemia	☐	Hepatitis/Liver Disease
☐	Vitamin D Deficiency	☐	Iron Deficiency	☐	Alcohol/Drug abuse
☐	Concussion	☐	Sickle Cell	☐	Vision Impairment (not glasses)
☐	TB/Lung Disease	☐	Thalassemia	☐	Hearing Impairment
☐	Seizure d/o	☐	Blood Clots	☐	Autism/Asperger's
☐	Diabetes	☐	Pulmonary Emboli (lung clots)	☐	ADD/ ADHD
☐	High Cholesterol	☐	DVT (leg clots)	☐	Autoimmune Disorder
☐	Thyroid Disease: Hypo ☐ Hyper ☐	☐	Heart Burn/Reflux	☐	Rheumatoid Arthritis
☐	HIV/AIDS	☐	Stomach Ulcers	☐	Crohn's or Ulcerative Colitis
☐	Migraine Headache	☐	Smoker	☐	Lupus
☐	Heart Murmur	☐	Anxiety	☐	Cancer
☐	Heart Disease	☐	Depression	☐	Other
☐	Valve Disorder	☐	Bipolar Disorder	☐	**NONE OF THE ABOVE**

If you selected any of the above, please describe:

FAMILY HISTORY (Please select all that apply to your immediate family: mother, father, sister, brother)

☐	Asthma	☐	Sudden cardiac death (before 50yrs)	☐	Suicide Attempts
☐	Clotting Disorder	☐	Heart Attack	☐	Gallbladder Disease
☐	Blood Clots	☐	High Blood Pressure	☐	Sleep Apnea/CPAP
☐	Pulmonary Emboli (lung clots)	☐	Arrythmia	☐	Ovarian Cancer
☐	DVT (leg clots)	☐	High Cholesterol	☐	Breast Cancer
☐	Stroke	☐	Diabetes	☐	Colorectal Cancer
☐	Heart Disease	☐	Mental Illness	☐	**NONE OF THE ABOVE**

Last Name	First Name MI	Date of Birth (MM/DD/YY)

MENTAL HEALTH INTERVENTIONS

Have you ever had any treatment or counseling for any emotional, behavioral or psychological condition?	Yes ☐ No ☐
Have you ever been treated with any medication for psychiatric reasons?	Yes ☐ No ☐

If you answered **yes** above, please provide the following:

- ✓ A full report from your physician, certified therapist or counselor is required.
- ✓ The full report will include a statement of diagnosis, treatment, response to treatment and need for follow up.
- ✓ This report should be directed to the MBU Office of Health Services, Head Athletic Trainer (if applicable) and Counseling and Psychological Services.
- ✓ This report will not be released without the written notice of the student.

SPECIAL NEEDS

Do you consider yourself handicapped or disabled in any way that requires you to receive special consideration from MBU?

☐ YES ☐NO - **(If yes, please provide details below)**

The Health Center works in cooperation with the Office of Student Engagement in attempting to meet the needs of students with special needs. May the health center refer your name to the following?

Office of Student Engagement:	Yes ☐ No ☐	**Accessibility Services Coordinator:**	Yes ☐ No ☐

**TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE **

Please answers questions below. Note: If you answer "Yes" to ANY question below, TB Testing IS required (page 4). Prior BCG Vaccine does NOT exempt one from this requirement (in this case, we recommend having IGRA Testing). ** If history of positive PPD, Chest X-Ray required and attached copy of the written report.

1. Do you have ANY of the following symptoms?				**Yes**	**No**
Persistent Cough	Yes ☐	No ☐	Unexplained fever for more than one week	☐	☐
Coughing up blood	Yes ☐	No ☐	Loss of appetite	☐	☐
Night Sweats	Yes ☐	No ☐	Unexplained weight loss	☐	☐
Chest Pain	Yes ☐	No ☐			

2. Do ANY of these situations apply to you?	**Yes**	**No**
History of positive PPD testing**	☐	☐
Close contact with someone diagnosed with or suspected of having tuberculosis Use of injected drugs	☐	☐
Identified as medically underserved or low income	☐	☐
At risk of being infected with HIV (Human Immunodeficiency Virus)	☐	☐
Volunteer, reside, or an employee in a healthcare facility or congregate living setting (homeless shelter, nursing home, correctional facility)	☐	☐
3. Do you have ANY of the following conditions that place you at increased risk for disease if infection occurs?	**Yes**	**No**
Silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemia, lymphoma, or cancer of the head, neck, or lungs), gastrectomy or jejunoileal bypass, or weight loss of at least 10% below ideal body weight	☐	☐
4. Were you born in another country listed in Table 1 (next page) AND did you (or will you) arrive in the U.S. within the past 5 years? (If yes, please list countries below)	☐	☐
5. Have you traveled within the last 5 years to one or more of the countries listed in Table 1 (next page) with a stay exceeding 4 weeks? (If yes, please list dates below)	☐	☐

PART II- IMMUNIZATION RECORD

ALL STUDENTS ARE REQUIRED *to submit a health record with documented immunizations to Mary Baldwin University in compliance with the Code of Virginia (section 23-7.5). All students with a positive IGRA or TST and no signs of active disease on chest x-ray should receive education and treatment recommendations for Latent Tuberculosis Infection (LTBI).*
Source: http://www.vdh.virginia.gov/tuberculosis/

STUDENT INFORMATION

Exam Date:

Last Name	First Name	MI	Date of Birth (MM/DD/YY)

REQUIRED VACCINES	Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given			
Tdap (one dose required on or after 10th birthday)	1			
Tetanus Booster (if Tdap > 10 years ago)	1			
Polio (IPV, OPV)	1	2	3	4
Measles, Mumps, Rubella (MMR) Vaccine	1	2		
Measles (Rubeola)	1	2	Or date of Serologic Confirmation of Measles Immunity (must attach copy of lab result):	
Rubella	1		Or date of Serologic Confirmation of Rubella Immunity (must attach copy of lab result):	
Varicella	1	2	Or date of Varicella Disease or Serologic Confirmation of Varicella Immunity (must attach copy of lab result):	
Mumps	1	2	Or date of Serologic Confirmation of Mumps Immunity (must attach copy of lab result):	
Meningococcal Vaccine (A, C, Y, W-135) **(Initial or booster dose must be on or after 16th birthday)** Required only for students < 22 years of age.	1			
Hepatitis B Vaccine ☐ 2-dose vaccine used to complete series.	1 / 2 / 3		Or date of Serologic Confirmation of Hepatitis B Immunity (must attach copy of lab result):	

Recommended Vaccines	Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given			
Hepatitis A	1	2		
Human Papillomavirus Vaccine (HPV)	1	2	3	
Serogroup B Meningococcal Vaccine ☐ MenB-4C ☐ MenB-FHpb	1	2	3	

REQUIRED TUBERCULOSIS SCREENING (all students):

TUBERCULOSIS (TB) RISK ASSESSMENT **(See on page 3)**	☐ Positive (any questionnaire response of "yes")	☐ Negative (all questionnaire responses "no")		
Tuberculosis Testing Result. **Required only if TB Risk Assessment is Positive.**	Result: ☐ Positive ☐ Negative	Test method: ☐ IGRA ☐ PPD	Date of Test:	Must attach copy of result for IGRA.
Chest X-ray result. **Required only if Tuberculosis Testing Positive.**	☐ Positive	☐ Negative	Date of test:	Must attach copy of report.
EXEMPTIONS Medical ☐ Religious ☐	**(Notarized letter MUST be submitted; Exemptions DO NOT apply to TB screening/testing)**			

HEALTH CARE PROVIDER INFORMATION

Provider Signature (MD, DO, NP, PA)	Provider Name (Print)	Date
Office Address	City/State	Zip
Office Website	Phone	Fax

Rev (05.14.2020)

TABLE 1

High Burden TB Country List 2020

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥20 cases per 100,000 population.
For future updates, refer to http://www.who.int/tb/country/en/

Afghanistan	Dominican Republic	Madagascar	Sao Tome and Principe
Algeria	Ecuador	Malawi	Senegal
Angola	El Salvador	Malaysia	Serbia
Anguilla	Equatorial Guinea	Maldives	Sierra Leone
Argentina	Eritrea	Mali	Singapore
Armenia	Eswatini (formerly Swaziland)	Marshall Islands	Solomon Islands
Azerbaijan	Ethiopia	Mauritania	Somalia
Bangladesh	Fiji	Mexico	South Africa
Bangladesh	French Polynesia	Micronesia (Federated States of)	South Sudan
Belarus	Gabon	Moldova (Republic of)	South Korea (Republic of Korea)
Belize	Gambia	Mongolia	Sri Lanka
Benin	Georgia	Morocco	Sudan
Bhutan	Ghana	Mozambique	Suriname
Bolivia	Greenland	Myanmar (Burma)	Tanzania (United Republic)
Bosnia and Herzegovina	Guam	Namibia	Tajikistan
Botswana	Guatemala	Nauru	Thailand
Brazil	Guinea	Nepal	Timor-Leste
Brunei Darussalam	Guinea-Bissau	Nicaragua	Togo
Bulgaria	Guyana	Niger	Tokelau
Burkina Faso	Haiti	Nigeria	Trinidad
Burundi	Honduras	Niue	Tunisia
Cabo Verde	India	Northern Mariana Islands	Turkmenistan
Cambodia	Indonesia	North Korea (Democratic People's Republic)	Tuvalu
Cameroon	Iraq	Pakistan	Uganda
Central African Republic	Kazakhstan	Palau	Ukraine
Chad	Kenya	Panama	Uruguay
China	Kiribati	Papua New Guinea	Uzbekistan
China, Hong Kong SAR	Kuwait	Paraguay	Vanuatu
China, Macao SAR	Kyrgyzstan	Peru	Venezuela
Colombia	Lao People's Democratic Republic	Philippines	Viet Nam
Comoros	Latvia	Portugal	Yemen
Congo	Lesotho	Qatar	Zambia
Cote d'Ivoire	Liberia	Romania	Zimbabwe
Democratic Republic of the Congo	Libya	Russian Federation	
Djibouti	Lithuania	Rwanda	

*If no countries selected, please discard this page after use - Do NOT submit with your Health Form

PART III- ATHLETIC MEDICAL QUESTIONNAIRE

ALL VWILL/ATHLETIC students **SUBMIT COMPLETED** form to their Physical Exam provider. *Circle any questions left unanswered.*

Last Name	First Name	MI	Date of Birth (MM/DD/YY)

GENERAL MEDICAL HISTORY	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐	27. Do you worry about your weight?	☐	☐
2. Do you currently have an ongoing medical condition? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Other	☐	☐	28. Are you trying to or has any professional recommended that you try to gain or lose weight?	☐	☐
3. Have you ever spent the night in the hospital?	☐	☐	29. Do you have groin pain or a painful bulge or hernia in the groin area?	☐	☐
4. Have you ever had surgery?	☐	☐	30. Have you had mononucleosis (mono) within the last month?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**	31. Have you ever had a heroes or MR.SA skin infection?	☐	☐
5. Does your heart race or skip beats during exercise?	☐	☐	32. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
6. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐	33. Are you currently taking any medication on daily basis?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	34. Have you ever had a head injury or concussion? If so, date of last injury:	☐	☐
8. Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection ☐ Kawasaki disease ☐ Other:	☐	☐	35. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?41. Have you had any problems with your eyes or vision?	☐	☐
9. Have you ever had an unexplained seizure?	☐	☐	36. Do you have headaches with exercise?	☐	☐
10. Has a doctor ever ordered a test for your heart? (For ex: ECG/EKG, echocardiogram)	☐	☐	37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
11. Do you get lightheaded or feel shorter of breath than expected during exercise?	☐	☐	38. When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**	39. Have you had any problems with your eyes or vision?	☐	☐
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome}?	☐	☐	40. Have you had any other blood disorders?	☐	☐
			41. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐	42. Do you wear glasses or contact lenses?	☐	☐
14. Does anyone in your family have a pacemaker or implanted defibrillator?	☐	☐	43. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
15. Docs anyone in your family have Marfan syndrome, cardiomyopathy, or Long Q-T?	☐	☐	44. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	☐	☐
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐	☐	45. Were you born without or are you missing a kidney, an eye, a testicle, spleen or any other organ?	☐	☐
BONE AND JOINT QUESTIONS			46. Do you limit or carefully control what you eat?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐	47. Have concerns that you would like to discuss with a doctor?	☐	☐
18. Have you had a bone or joint injury that required x rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐	48. What is the date of your last Tdap or Td(tetanus) immunization? (circle type) Date:	☐	☐
19. Have you had any broken or fractured bones or dislocated joints?	☐	☐	49. Do you have an allergy to medicine, food or stinging insects?	☐	☐
20. Have you ever had a stress fracture of a bone?	☐	☐	**FEMALES ONLY**	**Yes**	**No**
21. Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	☐	☐	50. Have you ever had a menstrual period?	☐	☐
			51. Age when you had your first menstrual period?		
			52. How many periods have you had in the last 12 mos.?		
22. Do you regularly use a brace or assistive device?	☐	☐	***"Yes" Answers: Type question # and a brief explanation below:***		
23. Do you currently have a bone, muscle, or joint injury that bothers you?	☐	☐	# >>		
24. Do any of your joints become painful, swollen, feel warm, or look red?	☐	☐	# >>		
25. Do you have a history of juvenile arthritis or connective tissue disease?	☐	☐	# >>		
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐	# >>		

Student Athlete's Signature **Parent/Guardian Signature** *(if under 18 yrs.)* **Date**

PART III - PHYSICAL EXAMINATION

[REQUIRED FOR ATHLETES AND VWIL CADETS ONLY]

STUDENT INFORMATION **Exam Date:**

First Name	Last Name	MI	Date of Birth (MM/DD/YY)

VITAL SIGNS:	Height	Weight	BP	Pulse	Temp	LMP	BMI

VISION:	Right	Left	Both	RX Lenses?	Contact Lenses
				Yes ☐ No ☐	Yes ☐ No ☐

Physical Examination	Normal	Abnormal	NOTES
HEENT	☐	☐	
Respiratory	☐	☐	
Cardiovascular	☐	☐	
Gastrointestinal	☐	☐	
Genitourinary (*testicles)	☐	☐	Glucose ☐ Protein ☐ Blood ☐ Leuk ☐
Musculoskeletal	☐	☐	
Metabolic/Endocrine	☐	☐	
Derm	☐	☐	
Lymph	☐	☐	
Neuro / Psychiatric	☐	☐	Include DTRs:
Additional Comments:			

* Testicle exam required for men participating in athletics

EMERGENCY MEDICATIONS REQUIRED ONSITE

☐ Inhaler	☐ Epinephrine	☐ Glucagon	☐ Other:	

CLEARANCE

☐	Cleared without restrictions for **ATHLETICS**
☐	Cleared without restrictions for **VWIL CADET TRAINING**
☐	Cleared with the following notation:
☐	Cleared **AFTER** documented further treatment for:
☐	Cleared for **LIMITED PARTICIPATION**
☐	**NOT CLEARED For Specific Sports: (Describe restrictions, sports, reasons, and dates below)**
☐	**NOT CLEARED FOR PARTICIPATION . (Describe reason below)**

HEALTH CARE PROVIDER: I have examined the above-named student and completed the preparticipation physical evaluation. I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for athletic student for participation in athletics. Only Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.

Provider Signature (MD, DO, NP, PA)	**Provider Name (Print)**	**Date**
Office Address	**City/State**	**Zip**
Office Website	**Phone**	**Fax**