

HEALTH RECORDS CHECKLIST FOR STUDENTS

The following health records are required to be able to participate in clinical experiences. Some clinical sites may have additional health related requirements, which include additional or repeat immunizations and/or titers. Specific requirements are provided prior to placement at each site. *It is the student's responsibility to meet these requirements for placement. For more information please refer to [Required Health Records Policy](#).*

COMPLETE, SIGN, AND UPLOAD ALL FORMS. Instructions and more information on [New Student Page](#) – Immunizations and Health Records.

FORM A – MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

This form allows Mary Baldwin University release the information to clinical sites as needed for clinical education experiences.

FORM B – PROOF OF INSURANCE

Health insurance is required. Ensure your policy provides adequate coverage while living in Fishersville, VA and on clinical rotations. Please provide a copy of the front and back of your insurance card. *Clinical assignments require proof of insurance. It is your responsibility to keep this information current to ensure eligibility for clinical assignments.*

FORM C – IMMUNIZATION RECORD

REQUIRED

- **MMR** (measles, mumps, rubella): 2 Measles (rubeola), 2 Mumps, 1 Rubella are required. 2 MMR vaccines or positive titers also meet this requirement.
- **Hepatitis B:** A completed series of 3 doses must be completed.
- **Varicella** (chicken pox): 2 documented varicella (chickenpox) vaccines OR a positive serological titer are required.
NOTE: An affidavit or documentation of having the disease is not accepted.
- **Tetanus Diphtheria, Pertussis:** A tetanus-diphtheria booster/Tdap is required within the past 10 years. Pregnant health care workers need a dose of Tdap during each pregnancy.
- **Influenza** - *Students entering in June are required to provide proof of immunization once the vaccine becomes available in the fall. Complete by Oct 31st. Required annually.*

RECOMMENDED (these or other immunizations may be required after arrival to the program)

- **Updated COVID-19 Vaccine:** Please refer to the [CDC website](#) for more information.
- **Hepatitis A:** 2 doses
- **Men ACWY vaccine:** 2 doses, protects against A, C, W, Y strains of meningococcal bacteria - causes meningitis and septicemia.
- **Men B vaccine:** 2 doses, protects against a 5th type of meningococcal bacterium, type B.

FORM D – TUBERCULOSIS TESTING/SCREENING

TB Skin Testing (2-Step). Newly enrolled students MUST undergo a 2-step tuberculin skin test (TST) OR have 1 Interferon Gamma Release Assay Test (IGRA) blood test for individuals who have had the BCG vaccine. A 2-step TST requires 4 visits. It must be performed in the US. Retest in 1 to 3 weeks after first TST result is read. Annual tuberculosis testing thereafter per program and clinic requirements. (Students should wait 4 weeks from last COVID vaccine to get blood or skin testing done.)

Form E – HEALTH CLEARANCE

Complete a physical examination before coming to Mary Baldwin University/ Murphy Deming College of Health Sciences. **A primary care provider must complete and sign the form provided.** This is the only form accepted to verify health information.

All students who have special situations/conditions regarding immunity are required to meet CDC recommended immunization requirements as specified. Information regarding current CDC guidelines for adults:

www.cdc.gov/vaccines/schedules/hcp/adult.html For more information please refer to [Required Health Records Policy](#).

CONTACT INFORMATION: Murphy Deming College of Health Sciences Admissions
540 887-4000
MDCHSAdmit@marybaldwin.edu

Instructions for Uploading Forms:

1. **Download and print MDCHS Health Forms.**
2. **Complete forms.**
 - Sign Form A – Medical Information Release Form (HIPAA Release Form).
 - Submit Form B with scan of front and back of current health insurance card.
 - Complete and have Form C signed by health care provider (MD, DO, PA-C, or NP-C).
 - Complete and have Form D signed by health care provider administering and reading TB 2-Step or performing blood test.
 - Complete and have Form E signed by health care provider (MD, DO, PA-C, or NP-C).
3. **Scan and upload forms to [New Student Page](#) – Immunizations and Health Records**
4. **Important: Keep a copy of your completed forms for your records.**

Key Notes:

- Forms may be submitted as they are completed. **You do not need to submit all at the same time.**
- If you need to complete certain immunizations, **you may submit Form C with a note of anything pending.** You may send the same form twice as they are updated, or send in additional documentation.
- **Forms are not complete until they are signed by the required party.**
- If you do not have access to a scanner, may we suggest using a phone app. Adobe Scan is free and works well. You may also upload a photo, but check the total size of the file. You may need to reduce the resolution and photo dimension settings.
- The student must upload each required form because your provider does not have access to the system. Please ensure all required documents are signed prior to uploading.
- **If a doctor's office provides supporting documentation, it CANNOT be a substitute for the form.** The provided MDCHS forms must each be completed and signed by the appropriate party.
- **Remember to keep copies of your forms and documentation.**
- Do not hesitate to reach out to MDCHSAdmit@marybaldwin.edu with any questions. We are here to help you complete the necessary requirements prior to the start of class.

Student's Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

FORM A – MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

This form allows Mary Baldwin University to release the information to clinical sites as needed for clinical education experiences.

Please complete all sections of this release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I: I give my permission for Mary Baldwin University to share the information listed in Section II of this document with the organization(s) specified in Section IV of this document.

Section II – Health Information:

I would like to give Mary Baldwin University permission to: (Check boxes as appropriate)

Release my limited health record including, physical exam, medical clearance, immunizations, TB screening, diagnostic and lab test results, and insurance information.

Form of Release:

Electronic copy or access via a web-based portal

Section III – Reason for Release

Information will be shared at student request or as required for clinical site/ supervised clinical practice experience verification.

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with

Clinical sites/supervised clinical practice experiences

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share information provided to them.

Section V – Duration of Authorization: This authorization to share my health information is valid from the date of the signature in section VI until terminated by me in writing or my last date of enrollment at Mary Baldwin University.

I understand:

- I am permitted to revoke this authorization at any time and can do so by submitting a request in writing to: Mary Baldwin University • Murphy Deming College of Health Sciences • 100 Baldwin Blvd • Fishersville, VA 22939
- In the event my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

Section VI – Signature: _____ Date: _____

Student's Name: _____

Date of Birth: _____

FORM B – PROOF OF INSURANCE

TO BE COMPLETED BY STUDENT AND SUBMITTED WITH COPY OF INSURANCE CARD

PROOF OF HEALTH INSURANCE	
Insurance Company	
Insurance Subscriber Name	
Insurance Policy #	
Insurance Company's Telephone Number	

NOTE: MUST SUBMIT FORM WITH A COPY OF FRONT AND BACK OF CURRENT INSURANCE CARD.

If you are planning to enroll in the **school student health insurance program**:

Write in box above: ***Enrolling in Student Health Insurance***

Provide copy of card when available online to New Student Page.

Information regarding the student health insurance provided separately.

*Completing this form **DOES NOT** substitute for completing the waiver process with the insurance company.*



Student's Name: _____

Date of Birth: _____

FORM C – VACCINATION RECORD

REQUIRED IMMUNIZATIONS	Dose #1 Date MM/DD/YY	Dose #2 Date MM/DD/YY	Dose #3 Date MM/DD/YY	Date of positive Immune Titer
1. MMR (Measles, Mumps, Rubella) – 2 Doses REQUIRED All doses of MMR, given singly or in combination, must be given after 1 year of age and at least one month apart. MMR requirement is only if born in 1957 or later.	____/____/____ After 1st Birthday	____/____/____ >4 weeks apart		Attach Documentation
-OR - MEASLES – 2 Doses REQUIRED	____/____/____	____/____/____		
MUMPS – 2 Doses REQUIRED	____/____/____	____/____/____		
RUBELLA (German Measles) – 1 Dose REQUIRED	____/____/____			
2. HEPATITIS B – 3 Doses REQUIRED	____/____/____	____/____/____	____/____/____	
3. VARICELLA (CHICKEN POX) – 2 Doses or Titer REQUIRED -OR -	Date of Disease ____/____/____ AND Date of Titer ____/____/____ Attach copy of QUANTITATIVE LAB REPORT.			
	Dose #1 Date ____/____/____		Dose #2 Date ____/____/____	
4. Tdap (Tetanus, Diphtheria, Pertussis) ____/____/____	Current Tdap within last 10 years. Some clinical sites may require an adult dose of Tdap.			
5. INFLUENZA Date: ____/____/____ Required annually by October 31.				
RECOMMENDED IMMUNIZATIONS				
COVID-19 Vaccine (Completed series required, number of doses may vary)	Manu. _____ Dose Date ____/____/____			
HEPATITIS A VACCINE	Dose #1 Date ____/____/____		Dose #2 Date ____/____/____	
Men ACWY	Dose #1 Date ____/____/____		Dose #2 Date ____/____/____	
Men B	Dose #1 Date ____/____/____		Dose #2 Date ____/____/____	

HEALTH CARE PROVIDER (MD, DO, PA-C, or NP-C)

Health Care Provider Signature: _____ Date: _____

Print Health Care Provider Name with Credentials: _____

Office Address, Telephone & Fax Number: _____

Student's Name: _____

Date of Birth: _____

FORM D – TUBERCULOSIS TESTING/SCREENING

REQUIRED: Newly enrolled students MUST undergo a two-step Tuberculin skin test (TST) OR have 1 Interferon Gamma Release Assay (IGRA) blood test. All testing and X-Rays must be done in the USA. **Annual tuberculosis testing thereafter per program requirements.** More info: www.cdc.gov/tb/topic/testing/healthcareworkers.htm

Students should wait 4 weeks from last COVID vaccine to get blood or skin testing done.
<https://www.cdc.gov/tb/publications/letters/covid19-mrna.html>

Two-Step TST

Test 1	Date placed: ___/___/___	Date read: ___/___/___	mm	positive	negative
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Test 1: Health Care Provider Signature: _____

Test 2	Date placed: ___/___/___	Date read: ___/___/___	mm	positive	negative
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Retest in 1 to 3 weeks after first TST result is read.

Test 2: Health Care Provider Signature: _____

IGRA (QFT Gold or T-Spot – TB blood test)

Date performed: ___/___/___	Result date: ___/___/___	positive	negative	Attach copy of lab report.
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Indeterminate or Borderline results are not acceptable. Repeat test or administer Two-step TST.

Chest X-Ray

Required ONLY if POSITIVE TST or POSITIVE IGRA. Chest X-ray must be after positive TST/IGRA and within 6 months of semester start date. A negative chest x-ray is not a substitute for tuberculosis testing. **Attach copy of x-ray report.**

Treatment for TB disease or Latent TB Infection

Dates of treatment regimen: ___/___/___ to ___/___/___ . **Attach documentation.**

INH Rifampin 3HTP (12 week DOT)

HEALTH CARE PROVIDER	
Health Care Provider Signature: _____	Date: _____
Print Health Care Provider Name with Credentials: _____	
Office Address, Telephone & Fax Number: _____	

Student's Name: _____

Date of Birth: _____

FORM E – PHYSICAL EXAM AND HEALTH CLEARANCE

Based on my assessment (the student's health history, immunization records, and physical examination), and to the best of my knowledge, I can attest to the following:

- The student is in satisfactory physical health to participate in a health professions education program including clinical experiences required by the program of study
- The student is in satisfactory mental health to participate in a health professions education program including clinical experiences required by the program of study
- Any limitations or accommodations to full participation are noted below.

HEALTH CARE PROVIDER (MD, DO, PA-C, or NP-C)

Health Care Provider Signature: _____ Date: _____

Print Health Care Provider Name with Credentials: _____

Office Address, Telephone & Fax Number: _____

Notes: