Checklist for Health Record Submission

Complete health record online and upload all page s to: https://bit.ly/MBUHealthForms

You may also FAX: 540-887-7289
Due JULY 1st for Fall Term DECEMBER 1st for Spring Term

ALL STUDENTS must complete **pages 1-5**

ALL Athletes, VWIL and ROTC **must *ALSO* complete pages 6-8**

PAGE 1 **Required Signature boxes at bottom of page** Please note: If your student is a MINOR, page 1 must be printed out, SIGNED by the parent/guardian and uploaded. Your student will not be able to receive care in Student Health if this is not completed.

PAGE 2 Please share your Medical History, Allergies, Medications

PAGE 3 **CERTIFICATE of IMMUNIZATION**

You may **EITHER**:

- upload an *official copy of your immunization record* that includes the required immunizations – IF done this way, no healthcare provider signature needed!
- **OR** have your healthcare provider fill out page 4 **AND SIGN IT**, then upload

Please note: REQUIRED vaccinations that must be included in the official record:

- Hepatitis B – 2 or 3 doses depending on the series given
- Measles, Mumps, Rubella – 2 doses
- Polio (IPV)
- Meningococcal (A,C,Y,W-135 also known as quadrivalent)
  - the most recent dose must be given ON or AFTER **your 16th birthday**
- Tdap or Td
  - within the last 10 years
- Varicella (chicken pox) – 2 doses or documented chicken pox

PAGE 4 **TB RISK ASSESSMENT**

Follow instructions. No signature needed if no risk factors/ testing indicated.

PAGE 5 **MENTAL HEALTH**

Any "yes" answers need a report from your provider sent to Counseling Services by fax or snail mail. See page 5 for more information.

WAIVERS & EXEMPTIONS

Complete and/or sign only IF NEEDED, and/or if you meet the criteria. Please read carefully.

PAGES 6,7,8 **SICKLE CELL TESTING, MEDICAL QUESTIONNAIRE AND PHYSICAL**

! To be completed by ATHLETES, VWIL and ROTC only
Do not delay in making an appointment for your physical

Questions? Call MBU Student Health at 540-887-7095

Upload to: https://bit.ly/MBUHealthForms OR FAX 540-887-7289

MARY BALDWIN UNIVERSITY

STUDENT HEALTH SERVICES

NAME _____ STUDENT ID _____ DATE OF BIRTH ____/____/____

CELL # (____)_____ Expected Graduation Year _____ Social Security # _____

HOME ADDRESS _____ City _____ State _____ ZIP _____

PARENT/GUARDIAN 1:

Name: _____

CELL # (____)_____ Relationship _____

Email Address _____

PARENT/GUARDIAN 2:

Name: _____

CELL # (____)_____ Relationship _____

Email Address _____

EMERGENCY CONTACT

Name: _____

CELL # (____)_____ Relationship _____

Email Address _____

HEALTH INSURANCE

Out-of-state Medicaid and Kaiser Permanente not accepted in Student Health.

Insurance: _____

Member ID: _____

Group#: _____

☐ First Year ☐ Transfer ☐ VWIL ☐ ROTC ☐ Athlete ☐ PEG ☐ MLitt/MFA

Parental/Guardian consent for treatment of students age 17 years and younger

The law requires that parental permission be obtained in order to provide medical care to minors. This consent form should be signed by the parents so that medical care may be carried out promptly without unnecessary delays.
I hereby authorize the nurse practitioner and staff nurse of MBU Student Health to examine, interview, test and, treat my son/daughter as they deem advisable.

Parent/Legal guardian signature _____ Date _____

I certify that the information in the entirety of this health form to be true and complete to the best of my knowledge. I release the information in this packet to authorized members of Mary Baldwin University staff, including, *when indicated*, VWIL, ROTC, PEG, Athletics and Counseling for the duration I am enrolled.

Student Signature _____ Student Name (Print) _____ (DOB) _____ Date _____

Parent signature if student is a minor _____

Upload completed health form to: https://bit.ly/MBUHealthForms Due Dates: July 1st Fall | December 1st Spring

NAME: _____ **Date of Birth:** _____

PRONOUNS: ☐ She/Her ☐ He/Him ☐ They/Them **Gender Identity:** _____

ALLERGIES:

- ☐ **NO KNOWN Medication ALLERGIES**
- ☐ MATERIAL allergies (latex): _____
- ☐ FOOD allergies: _____

Medication Allergies:

_____

_____

_____

MEDICAL HISTORY

- ☐ **NONE**
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma/ Reactive Airway
- ☐ Eczema
- ☐ Epilepsy / Seizures
- ☐ Migraine headaches
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Suicide attempt / date: _____
- ☐ Concussion / date: _____
- ☐ Diabetes Type _____
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Sickle cell (disease or trait)
- ☐ Autoimmune disorder
- ☐ Immune deficiency
- ☐ Bleeding problem
- ☐ Blood clots in legs or lungs
- ☐ Cancer: _____
- ☐ Colitis, Ulcerative/Crohn's
- ☐ Heart murmur/other heart problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Cerebral palsy
- ☐ Irritable bowel syndrome (IBS)
- ☐ Kidney infection, stones
- ☐ Mononucleosis / date: _____
- ☐ Scoliosis
- ☐ Autism
- ☐ Hearing loss
- ☐ Hepatitis / liver disease
- ☐ **OTHER**_____

MEDICATIONS

_____

_____

_____

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_____

FAMILY HISTORY

- ☐ **NONE**
- ☐ Asthma
- ☐ Blood clots (lung/ leg)
- ☐ Stroke
- ☐ Heart disease/ Heart attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Mental illness / suicide attempt
- ☐ Cancer: _____
- ☐ Gallbladder disease

SURGICAL HISTORY

(please list and include date)

- ☐ **NONE**

_____

_____

_____

For Clinic Use ONLY - leave column blank

CLINIC VISITS

LABS

MARY BALDWIN UNIVERSITY

Certificate of Immunization

All residential AND commuters attending in-person classes on campus are ***required*** to provide documentation of their immunizations and complete the TB Risk Assessment.

Graduate students (MFA, MLitt) *are only required to submit the TB Risk Assessment (page 4).*

	Immunization	Dose 1 (MM/DD/YY)	Dose 2 (MM/DD/YY)	Dose 3 (MM/DD/YY)	Dose 4 (MM/DD/YY)
	Required Immunizations				
† or † †	**Hepatitis B** *(check series received)* / ☐ TWINRIX OR ☐ HEPLISAV-B				
†	**Measles, Mumps, Rubella (MMR)** *After 1st birthday and ≥ 28 days apart*				
† †	**Meningococcal Vaccine (A, C, Y, W-135)** *One dose required **on/after 16th birthday** Required only for students < 22 years of age*				
	Polio *Required for 18 and under*				
	☐ **Tdap or** ☐ **Td** *(Current dose within 10 years)*				
†	**Varicella (Chicken Pox)** ☐ *2-dose series OR* ☐ *date of disease*				
	Recommended Immunizations				
	COVID-19 *List manufacturer for each dose and the date it was given (ex. Pfizer, Moderna, J&J, etc.)*				
	Hepatitis A				
	HPV: ☐HPV4 ☐ HPV9				
	Meningococcal Group B *MenB does not meet the Meningococcal Vaccine requirement above*				

Alternatives

† Attach lab result confirming serological immunity

† †Sign waiver on page 5 after reviewing the potential risks of not vaccinating in the link provided

Healthcare Provider or Health Department Signature** Date Phone

Name Date of Birth Student ID

NO signature needed if copy of Official Vaccine Record, including the required vaccines, is submitted!

MARY BALDWIN UNIVERSITY

Tuberculosis Risk Assessment

1) Screen for TB SYMPTOMS:

☐ Cough > 3 weeks ☐ Blood Tinged Sputum ☐ Fever > 7 days ☐ Unexpected Weight Loss ☐ Poor Appetite

☐ Night Sweats ☐ Fatigue ☐ None

2) Screen for TB RISK FACTORS:

☐ **Birth, travel, or residence in a country with an elevated TB rate**
TB testing is **REQUIRED** if you are from a country included in this list of high-burden TB countries per the WHO:
vdh.virginia.gov/content/uploads/sites/175/2022/02/High-Burden-TB-Countries-2022.pdf

IGRA is preferred over TST for non-US-born persons > 2 years old

Clinicians may make individual decisions based on the information supplied during the evaluation. Individuals who have traveled to TB-endemic countries for the purpose of medical or health tourism < 3 months may be considered for further screening based on the risk estimated during the evaluation.

☐ **Medical conditions increasing risk for progression to TB disease**

Radiographic evidence of prior healed TB, low body weight (10% below ideal), silicosis, diabetes mellitus, chronic renal failure or on hemodialysis, gastrectomy, jejunoileal bypass, solid organ transplant, head and neck cancer

☐ **Immunosuppression, current or planned**

HIV infection, injection drug use, organ transplant recipient, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone > 15 mg/day for > 1 month) or other immunosuppressive medication'

☐ **Close contact** to someone with infectious TB disease at any time

☐ **None**; no TB testing indicated at this time. **Heatlhcare provider signature not needed if no risk factors or symptoms present.**

If any boxes in either section 1 or 2 were checked (other than "none"), testing is REQUIRED.
Documentation of a NEGATIVE result is REQUIRED. **Must submit copy of negative report: either TB skin test or IGRA result

Complete this section ONLY IF history of POSITIVE Tuberculin skin test or IGRA (T-Spot or QFT).

*Positive TB Test Date: _____ Induration: _____ ****OR POSITIVE IGRA** Date: _____

*Enclose copy of positive TB test documentation

**Enclose copy of report; IGRA = Quantiferon Gold or T-Spot

Last Chest X-Ray Date: _____ Result: _____ Enclose copy of latest chest x-ray result

Have you taken medication for TB infection? ☐ Yes ☐ No

If Yes, Medication: _____ Date began: _____ Date completed: _____

For Healthcare Provider Use:

I have reviewed the above information and agree with the student's information as indicated above.

☐ LTBI treatment discussed ☐ LTBI brochure offered

_____

Healthcare Provider Signature Date

Name _____ DOB _____ Student ID # _____

MARY BALDWIN UNIVERSITY

Mental Health History

Have you ever had any treatment or counseling for any emotional, behavioral or psychological condition? ☐ Yes ☐ No

Have you ever been treated with medication for psychiatric reasons? ☐ Yes ☐ No

If you answered yes above, please submit the following to the attention Counseling Services via:
FAX: **(540) 887-7289** or MAIL: MBU Student Health, **201 N. Market St, Staunton, VA 24401**

✓ a report from your physician or licensed mental health provider is required
✓ the full report will include a statement of diagnosis, treatment, response to treatment and need for follow up

Waivers and Exemptions

Meningococcal Vaccine Waiver

I have read and reviewed information ***www.immunize.org/vis/meningococcal_acwy.pdf*** regarding the risk associated with meningococcal disease, availability and effectiveness of any vaccine against meningococcal disease and I ***choose not to be vaccinated against meningococcal disease.***

Student Signature or Parent/Legal guardian if a minor _____ Date _____

Hepatitis B Vaccine Waiver

I have read and reviewed information at ***www.immunize.org/vis/hepatitis_b.pdf*** regarding the risk associated with hepatitis B disease, availability and effectiveness of any vaccine against hepatitis B disease and ***I choose not to be vaccinated against hepatitis B disease.***

Student Signature or Parent/Legal guardian if a minor _____ Date _____

Medical Exemption

As specified in the Code of Virginia § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because:

☐ DTP/DTaP/Tdap ☐ DT/Td ☐ OPV/IPV ☐ Hib ☐ Pneum ☐ Measles ☐ Rubella ☐ Mumps
☐ HBV ☐ Varicella ☐ Meningococcal ☐ Covid ☐ This contraindication is permanent
☐ or temporary ☐ and expected to preclude immunizations until: Date (MM/DD/YY): _____

Signature MD, DO, NP, PA or/Health Department Official _____ Date _____

Religious Exemption

Any student who objects on the grounds that administration of immunizing agents conflicts with his or her religious tenets or practices shall be exempt from the immunization requirements unless an emergency or epidemic of disease has been declared by the Board of Health. An affidavit of religious exemption must be notarized and submitted on a Certificate of Religious Exemption (Form CRE-1) found online at
https://www.vdh.virginia.gov/content/uploads/sites/11/2016/04/cre_1.pdf

Name _____ DOB _____ Student ID # _____

Upload completed health form to: **https://bit.ly/MBUHealthForms**
Due Dates: **July 1st Fall | December 1st Spring**

MARY BALDWIN UNIVERSITY

ATHLETES, VWIL, and ROTC *ONLY*

You are REQUIRED to complete the next 3 pages (sickle cell screening, medical questionnaire and physical).

Part I - Sickle Cell Trait (SCT) Testing

- The NCAA requires that all NCAA DIII student-athletes have knowledge of their sickle cell trait status before the student-athlete participates in any intercollegiate athletic event, including strength and conditioning sessions, practice, competitions, etc.
- The VWIL and ROTC programs require this testing as well.
- If unable to show proof of prior testing by having your primary care physician complete the "Sickle Cell Trait Status" you must be tested to determine your sickle cell trait status.
- SCT Testing Instructions for Physicians: -SCT status must be determined using a sickle cell trait solubility test [Hgb S].
- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.
- Sickle cell trait is a common condition (> three million Americans)
- Although Sickle Cell trait is most predominently in African-Americans and those of Mediterranean, Middle Eastern, Indian, Carribean, and South and Central American ancestry. Persons of all races and ancestry may test positive for the sickle cell trait.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscle may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or "sickle" shape), which can accumulate in the bloodstream and "logjam" blood vessels, leading to collapse from the rapid breakdown of muscles starving of food.
- A sickling collapse is a medical emergency. Even the most fit athletes can experience a sickling collapse which can be fatal.

SICKLE CELL TRAIT STATUS VERIFICATION

Name:_____ Sport:_____

Date of Birth:_____ Year of Eligibility: ☐1 ☐2 ☐3 ☐4

Student I.D. #:_____ Local Phone #:_____

Local Address:_____

Please list the date of the Sickle Cell Trait testing:_____

Result of the Sickle Cell Trait testing: Negative_____ Positive_____

Are there any restrictions to participation: No restrictions_____

Restricted to_____

****Must be completed by a MD/NP/PA****

I verify that the above named individual's birth records show that he/she has been tested for Sickle Cell Trait using a SCT solubility test [Hgb S] OR if test results can't be obtained the individual was tested when receiving this form. The result of the test was:_____

Physician's signature:_____ Date:_____

Printed Physician's Name and Address:_____

The pre-participation physical examination is not a substitute for a thorough annual examination by a student's primary care physician.

PART II- MEDICAL HISTORY (Explain "YES" answers below)

This form must be complete and signed, prior to the physical examination, for review by examining practitioner.
Explain "YES" answers below with number of the question. Circle questions you don't know the answers to.

GENERAL MEDICAL HISTORY	YES	NO
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical conditions? If so, please identify: ☐ Asthma ☐Anemia ☐Diabetes ☐ Infections ☐Other: _____	☐	☐
4. Are you currently taking any medications or supplements on a daily basis?	☐	☐
5. Do you have allergies to any medications?	☐	☐
6. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?	☐	☐
7. Have you ever spent the night in the hospital? If yes, why? _____	☐	☐
8. Have you ever had surgery?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
9. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐	☐
10. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
11. Does your heart race, flutter in your chest or skip beats (irregular beats) during exercise?	☐	☐
12. Has a doctor ever ordered a test for your heart? For example, electrocardiography or echocardiography.	☐	☐
13. Has a doctor ever told you that you have any heart problems, including: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki Disease ☐ Other _____	☐	☐
14. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
15. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
16. Does anyone in your family have a heart problem?	☐	☐
17. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)?	☐	☐
18. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
19. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐
BONE AND JOINT QUESTIONS	**YES**	**NO**
20. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
21. Do you currently have a bone, muscle or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**YES**	**NO**
22. Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
23. Do you have asthma or use asthma medicine (inhaler, nebulizer)?	☐	☐

MEDICAL QUESTIONS CONTINUED	YES	NO
24. Have you had mononucleosis (mono) within the last month?	☐	☐
25. Are you missing a kidney, eye, testicle, spleen or other internal organ?	☐	☐
26. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
27. Have you ever become ill while exercising in the heat?	☐	☐
28. When exercising in the heat, do you have severe muscle cramps?	☐	☐
29. Do you have headaches with exercise?	☐	☐
30. Have you ever had numbness, tingling or weakness in your arms or legs or been unable to move your arms or legs AFTER being hit or falling?	☐	☐
31. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
32. Have you had any other blood disorders?	☐	☐
33. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?	☐	☐
34. Have you had or do you have any problems with your eyes or vision?	☐	☐
35. Do you wear glasses or contacts?	☐	☐
36. Do you wear protective eyewear like goggles or a face shield?	☐	☐
37. Do you worry about your weight?	☐	☐
38. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
39. Do you limit or carefully control what you eat?	☐	☐
40. Have you ever had an eating disorder?	☐	☐
41. Are you on a special diet or do you avoid certain types of foods or food groups?		
42. Allergies to food or stinging insects?	☐	☐
43. Have you ever had a COVID-19 diagnosis? Date:	☐	☐
44. What is the date of your last Tdap or Td (tetanus) immunization? (circle type) Date: _____		
FEMALES ONLY	**YES**	**NO**
45. Have you ever had a menstrual period?	☐	☐
46. Age when you had your first menstrual period: _____		
47. Number of periods in the last 12 months: _____		
48. When was your most recent menstrual period? _____		

EXPLAIN "YES" ANSWERS BELOW

>>

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>>

List medications and nutritional supplements you are currently taking here:

→ **Student Name:** _____ → **Date of Birth:** _____

→ **Parent/Guardian Signature:** _____ **Date:** _____ → **Athlete's Signature:** _____

PART III- PHYSICAL EXAMINATION

(Physical examination form is required each school year dated after *May 1* of the preceding school year and is good through June 30 of the current school year)**

NAME_____ **DATE OF BIRTH**_____ **SCHOOL**_____

Height	Weight	☐ Male	☐ Female
BP /	Resting pulse	Vision R 20/ L 20/	Corrected ☐ Yes ☐ No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance (Marfan stigmata: kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse, and aortic insufficiency)		
Eyes/ears/nose/throat (Pupils equal, hearing)		
Lymph nodes		
Heart (Murmurs: auscultation standing, supine, +/- Valsalva)		
Pulses		
Lungs		
Abdomen		
Skin (Herpes simplex virus, lesions suggestive of MRSA or tinea corporis)		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional (i.e. Double leg squat, single leg squat, box drop or step drop test)		
Emergency medications required on-site: ☐ Inhaler ☐ Epinephrine ☐ Glucagon ☐ Other:		
COMMENTS:		

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics:

☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION**

☐ **MEDICALLY ELIGIBLE FOR ALL SPORTS WITHOUT RESTRICTION WITH RECOMMENDATION FOR FURTHER EVALUATION OR TREATMENT OF:**

_____

☐ **MEDICALLY ELIGIBLE <u>ONLY</u> FOR THE FOLLOWING SPORTS:**_____

Reason:_____

☐ **<u>NOT</u> MEDICALLY ELIGIBLE PENDING FURTHER EVALUATION OF:** _____

☐ **<u>NOT</u> MEDICALLY ELIGIBLE FOR ANY SPORTS**

By this signature, I attest that I have examined the above student and completed this pre-participation physical including a review of Part II- Medical History.

→ **PRACTITIONER SIGNATURE:** _____ **(MD, DO, NP or PA)+ DATE**:** _____

EXAMINER'S NAME AND DEGREE (PRINT): _____ PHONE NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

+Only signature of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant <u>licensed to practice in the United States</u> will be accepted.

Rule 28B-1 (3) Physical Examination Rule/Transfer Student (10-90)- When an out-of-state student who has received a current physical examination elsewhere transfers to Virginia and attaches proof of that physical examination to the League form #2, the student is in compliance with physical examination requirements.