

Checklist for Health Record Submission

Complete health record online and upload all pages to: bit.ly/HealthRecordsUpload

You may also **FAX: 540-887-7289**

Due **JULY 1st** for Fall Term **DECEMBER 1st** for Spring Term

All student will need to complete pages 1-3
Athletes will also complete pages 5-7

PAGE 1 GENERAL INFORMATION

PAGE 2 CERTIFICATE of IMMUNIZATION

- 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 1 **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 3 TB RISK ASSESSMENT

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

PAGE 4 WAIVERS & EXEMPTIONS

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

PAGES 5-7 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/HealthRecordsUpload>

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) / <input type="checkbox"/> TWINRIX OR <input type="checkbox"/> 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 Date when series was completed				
	<input type="checkbox"/> Tdap or <input type="checkbox"/> Td (Current dose within 10 years)				
Recommended Immunizations					
†	Varicella (Chicken Pox) <input type="checkbox"/> 2-dose series OR <input type="checkbox"/> date of disease				
	COVID-19 List manufacturer for each dose and the date it was given (ex. Pfizer, Moderna, J&J, etc.)				
	Hepatitis A				
	HPV: <input type="checkbox"/> HPV4 <input type="checkbox"/> 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!

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: bit.ly/HealthRecordsUpload

Due Dates: **July 1st Fall | December 1st Spring**

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 predominantly in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean and South and Central American ancestry, persons of all races and ancestry may test positive for 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: _____

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	<input type="checkbox"/> Male	<input type="checkbox"/> Female
BP /	Resting pulse	Vision R 20/	L 20/
		Corrected	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Inhaler <input type="checkbox"/> Epinephrine <input type="checkbox"/> Glucagon <input type="checkbox"/> 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 ONLY FOR THE FOLLOWING SPORTS:** _____
Reason: _____
- NOT MEDICALLY ELIGIBLE PENDING FURTHER EVALUATION OF:** _____
- NOT 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 licensed to practice in the United States 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.