HOLLINS UNIVERSITY

Health and Immunization Record

COMMONWEALTH OF VIRGINIA LAW AND/OR HOLLINS UNIVERSITY REQUIRES THAT THE HEALTH RECORD FORM AND CERTIFICATE OF IMMUNIZATION BE COMPLETED AND SUBMITTED TO THE STUDENT HEALTH CENTER PRIOR TO ENROLLMENT AT HOLLINS UNIVERSITY.

Send directly to: Hollins University, Health and Counseling Services, P. O. Box 9644, Roanoke, VA 24020-1644.
Questions: call (540) 362-6444, fax (540) 362-6273.

This completed form must be returned by July 1 for fall semester and December 1 for spring semester.

Section I: Personal Information

Name LE (Last) VAN (First) HAI (Middle) **Student ID#** A00434123 (Student ID # is Required to Process this form.)

Date of Birth 01 (Mo) / 17 (Day) / 2001 (Year) **Sex** Female **Marital Status** Single

Local Address (If living off campus) No. & Street _____ City _____ State _____ Zip _____ **Cell Phone** (____) _____

Permanent Home Address Lo 10, Lien ke 8, Dong Son Urban Area, An Hoach Ward, Thanh Hoa, Vietnam **Telephone** (84) 948884369

Parent/Guardian Email Address letientruong67@gmail.com

In Case of Emergency, Notify LE TRUONG TIEN (Name) (84) 913755973 (Telephone) Father (Relationship)

Family Physician _____ (Name) _____ (Address)

Medical Insurance Company _____ (Name) **Policy No.** _____

Type of plan: ☐ HMO ☐ PPO ☐ Indemnity ☐ Other ☑ Uninsured

It is recommended to include a copy (front & back) of your insurance card and/or prescription card. We will use this information for prescriptions and any outside referrals.

. MEDICAL CENTER
CTOR CLINIC
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Medical History (Confidential)

1. **Name any chronic illness or medical conditions for which you are being treated. Please also list any hospitalizations/surgeries:**
   No

2. **List any medications you are currently taking:**
   No

3. **List any medicine, food, or environmental substance to which you are ALLERGIC and describe allergic reaction.**
   No

Over 18: I, hereby, give the Student Health Center permission to treat me whenever I present myself to the Center.

Student's Signature _____ Date 2 July 2019

Under 18: Statement must be signed if student is under 18 years of age. I/we, the parents of _____ hereby authorize and give permission to the Student Health Center to treat my/our child whenever my/our child presents to the Health Center.

_____ _____

Section II: Immunization Record

IMPORTANT REQUIREMENT

Commonwealth of Virginia Law and Hollins University require all students to submit a health record with documented immunizations. This MUST be signed by a health care provider. All immunizations must be current.

In case of an incomplete immunization record, preregistration for the following semester will be blocked.

REQUIRED IMMUNIZATIONS	VACCINE DOSES ADMINISTERED			
HEPATITIS B (For *combined Hep. A + B*, do not use this line. Instead, check here:____ and complete the appropriate line in "*Recommended but Not Required*") Titer ☐ Pos ☐ Neg ___/___/___ Mo Day Yr	#1 01/17/01 Mo Day Yr	#2 03/17/01 Mo Day Yr	#3 05/17/01 Mo Day Yr	Date series completed ___/___/___ Mo Day Yr
MENINGOCOCCAL VACCINE Must have at least one vaccine after the age of 16 BC	#1 06/12/18 Mo Day Yr	#2 08/12/18 Mo Day Yr		
MEASLES, MUMPS, RUBELLA (MMR) Students born before 1957 are not required to have a second MMR vaccination.	#1 03/10/02 Mo Day Yr	#2 03/10/05 Mo Day Yr	Titers only needed if dates unavailable Measles Titer ☐ Pos ☐Neg ___/___/___ Mumps Titer ☐ Pos ☐ Neg ___/___/___ Rubella Titer ☐ Pos ☐ Neg ___/___/___	
TETANUS DIPHTHERIA Adult pertussis **(TDAP)** On or after 2006	10/24/16 Mo Day Yr			
POLIOMYELITIS (OPV or IPV)	Have you completed the series? ☑ yes ☐ no		05/18/04 Date completed	
VARICELLA (two doses one month apart for adults with no history of disease)	#1 04/10/02 Mo Day Yr	#2 08/05/06 Mo Day Yr	☐ Had Disease Date: ___/___/___	Titer ☐ Pos ☐ Neg ___/___/___

RECOMMENDED - PLEASE INCLUDE VACCINATION DATES			
HPV, Quadrivalent or Bivalent (age 26 and under)	#1 ___/___/___	#2 ___/___/___	#3 ___/___/___
HEPATITIS A	#1 ___/___/___	#2 ___/___/___	
Combined Hepatitis A + B Vaccine Hepatitis B is required. See above.	#1 ___/___/___	#2 ___/___/___	#3 ___/___/___
PNEUMOCOCCAL VACCINE (high-risk persons)	#1 ___/___/___		

HEALTH CARE PROVIDER This form will not be accepted if not signed by a health care provider

HOAN KIEM DISTR. MEDICAL CENTER
FAMILY DOCTOR CLINIC
50C HANG BAI HA NOI

Printed Name ______ Phone (+84) 39431522

Address 50C - Hang Bai - Ha Noi - Viet Nam

Signature ______ Medical Doctor's Date Jul - 02 - 2019

NGO HY

†MEDICAL EXEMPTION

☐ DTP ☐ Td ☐ Hepatitis B ☐ Measles ☐ Rubella ☐ Mumps ☐ Meningococcal Vaccine ☐ OPV

As specified in §23-7.5 of the Code of Virginia, I certify that administration of the vaccine(s) designated above would be detrimental to this student's health.

The vaccine(s) is (are) specifically contraindicated because ____________

This contraindication is ☐ permanent (or) ☐ temporary and expected to preclude immunization until ____________

Signature of Physician or Health Department Official ____________ Date ______

†Religious Exemption: Any student who objects on the grounds that administration of immunizing agents conflicts with his 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 submitted on a Certificate of Religious Exemption (Form CRE-1) which may be obtained at any local health department, school division superintendent's office or local department of social services.

Tuberculosis Screening: Required Of All Students

Fill out the first section and take to your health care provider with your immunization record

LE HAI VAN | 01/11/01 | A00434123

Name | Date of Birth | Student ID Number

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER. TB screening must be completed within six months.
Please answer the following questions.

1. **Does the student have signs or symptoms of active TB disease?** ☐ YES ☑ NO

   If NO, proceed to question 2.

   If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, QFT-TB test, chest x-ray and sputum evaluation as indicated. Documentation required that all tests are negative or that treatment is effective and student free of communicable disease.

2. **Is the student a member of a high-risk group?** ☐ YES ☑ NO

   Categories of high-risk students include those: with HIV infection; who inject drugs; who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone > 15 mg/d for > 1 month) or other immunosuppressive disorders.

   If NO, continue to question 3.

   If YES, obtain QFT (preferred) or perform TST

   QFT-TB Date obtained: 08/02/19 **Result:** ☐ Positive ☑ Negative

   OR TST: Date given: ___/___/___ Date read: ___/___/___ Result: _____mm (transverse induration

   Interpretation (based on mm of induration as well as risk factors) ☐ Positive ☐ Negative

   If positive, please obtain QFT: Date obtained: ___/___/___ **Result:** ☐ Positive ☐ Negative

   If positive QFT, obtain CXR (if symptoms):

   Date: ___/___/___ **Result:** ☐ Normal If abnormal CXR, return to Question 1 - yes
   If normal CXR, INH initiated Date: ___/___/___ Completed: ___/___/___

3. **Was the student born in or has the student traveled to countries OTHER than those on the following list?** ☑YES ☐NO

   Albania, American Samoa, Andorra, Antigua and Barbuda, Aruba, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Curacao, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Monaco, Montenegro, Montserrat, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tokelau, Tonga, Trinidad & Tobago, United Arab Emirates, United Kingdom, United States Virgin Islands, West Bank and Gaza Strip, United States of America

IF NO, Please sign below.*

If YES, obtain QFT: Date obtained: 08/12/19 **Result:** ☐ Positive ☑ Negative (If negative, sign below)

If positive without symptoms, INH initiated Date: ___/___/___ Completed: ___/___/___

HOAN KIEM DIST.
FAMILY DO
50C HANG

HEALTH CARE PROVIDER *Signature required as validation of correct information for TB assessment
*This form will not be accepted if not signed by a health care provider

Printed Name M- DR NGO HY Phone (+84)39431522

HOAN KIEM DIST.
FAMILY DOCTOR CLINIC
50C HANG BAI - HA NOI

Medical Doctor's
NGO HY

HOAN KIEM DISTR. MEDICAL CENTER
FAMILY DOCTOR CLINIC
50C HANG BAI - HA NOI

Address 50c - Hang Bai - Ha Noi - Viet Nam

Signature _____ Date 31-02-2019

Student's Name: LE HAC VAN HA Date of Birth 01/12/2001

Medical Doctor's
NGO HY

Section III: Physician's Health Evaluation (exam within twelve months of entering Hollins University)

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all abnormal answers. The information supplied will be used only as a background for providing health and mental health care, if this is necessary. This information is strictly for the use of the Health and Counseling Services and will not be released without student consent.

Exams by parent or legal guardian not accepted

Height (inches) 162 cm
Weight (lbs.) 50kg
Temperature 36,5°C
Blood Pressure 90/60
Pulse 90/min

Un-Corrected vision
Right 20/___
Left 20/___

Corrected vision
Right 20/20
Left 20/20

Hearing
Right Normal
Left Normal

Urinalysis
Sugar Negative
Micro (if indicated) Negative
Albumin Negative
Other _____
Hemoglobin 140g/l or Hematocrit 41%

PLEASE INDICATE ANY ABNORMALITIES IN THE FOLLOWING:

	Normal	Abnormal		Normal	Abnormal
Skin	acnes on the face		Breasts	✓	
Lymph	✓		Lungs	✓	
Eyes	Short sighted		Heart	✓	
Ears	✓		Abdomen	✓	
Nose	✓		Back/spine	✓	
Mouth/throat	✓		Genitalia	✓	
Neck/thyroid	✓		Extremities	✓	
			Neurological	✓	

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: ☐ Limited ☑ Unlimited

How long have you known this student? 1 day

Is the patient now under treatment for any medical or emotional condition? ☐ Yes ☑ No

Does student take any medications regularly? ☐ Yes ☑ No

Do you have any recommendations regarding the care of this student? ☐ Yes ☑ No

Comments _____

If patient is prescribed medication for ADD/ADHD, a letter from the physician with documentation is required.

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