Averett University
Health Form

To All Students:

Based on a recommendation from the Virginia Department of Health and the American College Health Association, **Averett University requires that current health and immunization records be on file for all students.** Information contained herein is confidential as a part of your records and will not be disclosed without your written permission, except in the event of an emergency.

To Be Completed By Student *(please print)*

Name_____ _____
(Last) (First) (Middle) Student ID#

Sex ____ Marital Status ____ Date of Birth _____ College Entrance Date _____ Freshman ____ Transfer ____

Home Address _____
(Street)

_____
(City) (State) (Zip Code)

Home Phone _____ Cell Phone _____

Students Must Answer All Questions
Personal Medical History

Have you ever had the following?

Asthma/Bronchitis	No___ Yes___	Diabetes	No___ Yes___	Thyroid Disease	No___ Yes___
Chickenpox	No___ Yes___	Mental Health Issues	No___ Yes___	Pneumonia	No___ Yes___
Frequent Cold/Sinus Infection	No___ Yes___	ADD/ADHD	No___ Yes___	Pelvic Infections/ STD's	No___ Yes___
Hypertension	No___ Yes___	Depression/ Anxiety	No___ Yes___	Menstrual Problems	No___ Yes___
Heart Disease/Heart Murmur	No ___Yes ___	Suicidal Thoughts	No___ Yes___	Recurrent Bladder/ Kidney Problems	No___ Yes___
Fainting Spells/ Dizzy	No___ Yes___	Eating Disorder	No___ Yes___	Sickle-Cell Disease	No___ Yes___
Epilepsy/Seizures	No___ Yes___	Fatigue	No___ Yes___	Migraines/Chronic Headaches	No___ Yes___
Head Injury/Concussion	No___ Yes___	Mono	No___ Yes___	Scoliosis	No___ Yes___
Irritable Bowel/ Spastic Colon	No___ Yes___	Hepatitis	No___ Yes___	Hearing Problems	No___ Yes___
		Obesity	No___ Yes___		
		Abnormal Bruising	No___ Yes___		
		Anemia	No___ Yes___		

Details of above, if necessary:

_____

_____

Please complete the following:

List dates of any serious injuries, hospitalizations, illnesses or operations.
❒ None or, if applicable, please list_____

Describe any emotional disturbances or adjustment problems.
❒ None or, if applicable, please describe_____

List any medications you are currently taking, including dosage and scheduled administration.
❒ None or, if applicable, please list_____

Are you allergic to any medications? Yes____ No____ Specify _____

Other allergies: _____

Terms

Information on this form may be necessary in the event of an emergency. All omissions or incomplete information on this form are the responsibility of the student and his/her healthcare provider. **This completed form must be filed at Averett University at the beginning of the school year.**

Student's Signature _____ **Date** _____

Emergency Contact Information:

Name: _____
Address: _____
City/State: _____
Phone #: _____
Relationship: _____

Name: _____
Address: _____
City/State: _____
Phone #: _____
Relationship: _____

Required Immunizations
MUST BECOMPLETED BY A PHYSICAN

An official copy (high school transcript, health department, medical provider) of the following immunizations **must** be attached to this health form.

- **MMR # 1** _____
- **MMR # 2** _____
- **Tetanus** *(T.D., tdap - must be within last 10 years)* _____
- **Polio** _____
- **Hepatitis B Series** _____, _____, _____

- ***Recommended*** *(but not required)* ***Immunization -- Meningococcal Vaccine*** *Date of shot* _____
  I have reviewed the Averett University Statement on Recommended Immunizations available at www.averett.edu. I have been informed and understand the benefits of the meningococcal vaccine and decline to receive the immunization.

Student's signature for waiver _____ *Date* _____

- **Tuberculosis Screening** (complete both questions 1 and 2)

  1. Does the student have signs or symptoms of active TB disease? No____Yes ____
     If No, proceed to question 2.

  2. Is the student a member of a high-risk group or is the student entering the health profession? No____Yes ____
     If YES, perform TB skin test (Mantoux only).

- **Tuberculin Skin Test** (within one year) Date given _____ Date read _____ Induration _____mm
  Positive ___ Negative ___ **Chest X-ray** (required if skin test is positive) Date _____ Report Results _____

Physician/PA/NP Signature _____ **Date** _____

Physician/PA/LP Last Name (Print) _____

Address _____

Telephone Number _____

Return to: Jill Adams, Assistant Dean of Students/Title IX Coordinator
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