Health Services

Health History/Immunization Record

Student Health Services
Old Dominion University
1007 South Webb Center
Norfolk, Virginia 23529

Telephone (757) 683-3132
Fax (757) 683-5930
http://studentaffairs.odu.edu/healthservices

The pre-entrance health record/immunization form is due August 1st for full-time students enrolling in the Fall semester and January 2nd for students enrolling in the Spring. Do not submit form until ALL information is complete. We require you to complete all vaccines (the Hepatitis B series should be started and may be completed during the school year). However, your immunization status will not be complete until all 3 doses have been received.

Virginia state law and Old Dominion University require all full-time students taking at least one credit on the Norfolk campus who enroll for the first time, to provide documentation of immunizations by a licensed health professional or health facility. Information regarding dates of immunizations is usually available from your health care provider or last high school attended. **Students will not be allowed to register for second semester until requirements have been met.**

All full-time students admitted to Old Dominion University must provide health information. Some questions are of a personal nature. It is necessary, however, to complete all questions in order to properly evaluate each student's risk factors for tuberculosis (TB) exposure or infection.

To ensure that we can review this form in time for registration, please have all required immunizations completed and recorded. The information on this pre-entrance health record is needed to both protect the health of the university community and to assist Student Health Services staff to provide for medical needs while a student is attending Old Dominion University.
Students should bring a copy of their health insurance card with them to campus.
We recommend any necessary dental and eye examinations be done before coming to the University. Student Health Services is unable to provide these services.

Student Health Services gives allergy injections at regularly scheduled times. A physician's detailed orders are required. If starting a series of allergy shots, we require that the ordering physician give the first injection.

Please refer to our FAQ's on our website for more information.

Submit original and keep a copy of this completed form for your records.

This form must be returned to Student Health Services by fax or mail. Please do not do both.

PART A. To be completed by student

Last Name	First Name	Middle Initial	University Identification No.

Permanent Home Address Street	City	State	Zip	Phone

Year/Semester Entering ODU	Birthdate (mm/dd/yyyy)	Sex: M F	Ethnicity	Height: (ft. in.)	Weight: (lbs.)

Person to notify in case of emergency	Relationship	Phone (H)	Phone (Cell)

School Status: ❑ Full-time undergraduate ❑ Part-time undergraduate ❑ Full-time graduate ❑ Part-time graduate

Have you previously submitted an immunization report? ❑ YES ❑ NO **E-mail:**

Insurance: All students are recommended to have health insurance.
International students must have health insurance. Do you have health insurance? ❑ YES ❑ NO

Insurance Company	Policy Holder	I.D./Group Number

Family History – **Check if condition exists in your family (immediate family, grandparents, aunts, uncles, cousins)**

Cancer_____
Diabetes_____
Heart Disease_____
High Blood Pressure_____
Kidney Disease/stones_____
Asthma/Lung Disease_____
Psychiatric Disorders_____
Suicide_____
Tuberculosis_____
Family History of sudden death before age 50
Yes____ No____

Personal Medical History

Allergies to Food, Drugs, Animals, Dust, Pollen, etc. List_____

Medicines routinely taken: (name, dosage, and frequency): _____

_____

Do you have a history of any of the following medical conditions? Provide details of positive answers below.

	Yes	No		Yes	No		Yes	No		Yes	No
Allergies, Hay Fever	❑	❑	Diabetes	❑	❑	Kidney infection/stone	❑	❑	Menstrual problems	❑	❑
Anemia	❑	❑	Diseases/injury of			Mononucleosis	❑	❑	Breast problems	❑	❑
Anxiety	❑	❑	bones/joints/muscles	❑	❑	Seizure disorder	❑	❑	Testicular problems	❑	❑
Asthma	❑	❑	Eating Disorder	❑	❑	Stomach/intestinal			Other	❑	❑
Bleeding Disorder	❑	❑	Heart disease/murmur	❑	❑	disorder/ulcers	❑	❑			
Cancer or malignancy	❑	❑	Hepatitis or liver disease	❑	❑	Substance/alcohol abuse	❑	❑			
Depression	❑	❑	High Blood Pressure	❑	❑	Thyroid disorder	❑	❑			

_____

_____

Any other illness: _____

Hospitalizations: _____

Surgery: _____

Please describe any prior or current treatment by a mental health provider such as a psychiatrist, psychologist or counselor. _____

_____

_____

PERMISSION FOR TREATMENT
I understand that the information that I have given in the Pre-entrance Health Record is confidential and for the use of attending medical staff. I give permission to Old Dominion University to provide diagnostic, therapeutic, voluntary immunization, operative procedures and transportation as deemed necessary by the medical staff on my behalf. I understand that my health information will be used as necessary to coordinate and manage my health care, support the operations of Student Health Services and to comply with state/federal laws.

DEEMED CONSENT FOR HIV TESTING (VIRGINIA STATE LAW) 32.1-45.1
Testing required if direct exposure to body fluids outlined in CDC guidelines.

AUTHORIZATION OF PAYMENT
I hereby authorize Old Dominion University to bill me for services provided. I will be responsible for any legal and/or collection fees resulting from non-payment. Permission is given to Old Dominion University, Student Health Services to release information upon request regarding claim for the noted charges, to my insurance company, to facilitate payment of insurance claims.

I have been informed of and understand the above statements regarding permission for treatment, deemed consent and authorization of payment.
Student's Signature_____(No treatment will be given if not signed) Date ___/___/___

FOR STUDENTS UNDER 18 YEARS: CONSENT FOR TREATMENT OF MINORS
This consent form must be signed by the natural parent or legal guardian of minors (under 18 years) so that appropriate diagnosis and treatment may be promptly carried out, and so that no unnecessary delays will occur with health service procedures. Under certain circumstances the student will be transported to local hospitals for diagnosis and treatment. I have been informed of and understand the above statements regarding permission for treatment, deemed consent and authorization of payment.

I give permission for such diagnostic, therapeutic, voluntary immunization, operative procedures and transportation as deemed necessary for my son/daughter who is under the age of eighteen (18) years. No treatment will be given if not signed.
Parent/Guardian Name _____ Parent/Guardian Signature _____ Date ___/___/___

Part B. Tuberculosis Risk Assessment Must Be Completed By Student

Name:_____ UIN:_____

The United States Public Health Service and the Centers for Disease Control and Prevention recommend that tuberculosis screening be performed in all individuals who may be at increased risk of tuberculosis.

Place a check in the yes or no boxes in front of any section. A TB skin test or IGRA blood test is required if yes is checked in any section.

❑ **Yes** ❑ **No** **Section 1: Check if you have any of the following symptoms**:

- Persistent cough of unknown etiology for more than 3 weeks
- Coughing bloody sputum
- Unexplained fever for more than 1 week
- Unexplained weight loss
- Night sweats
- Chills
- Fatigue
- Loss of appetite

❑ **Yes** ❑ **No** **Section 2: Check if any of these situations apply to you:**

- Close contact with a known or suspected case of active tuberculosis
- Use of illegal injected drugs
- At risk of being infected with HIV (Human Immunodeficiency Virus)
- Volunteer, resident, or employee in a healthcare facility or congregate living setting (homeless shelter, nursing home, correctional facility)

❑ **Yes** ❑ **No** **Section 3: Check if you have any of the following health condition risk for tuberculosis:**

- Gastrectomy, jejunoileal bypass, or chronic malabsorptive conditions
- Prolonged corticosteroid therapy or other immunosuppressive therapy; chemotherapy
- On any TNF antagonist medication (such as Humira, Embrel, or Remicade)
- Diabetes
- Chronic renal failure or on dialysis
- Solid organ transplant (kidney, heart)
- HIV infection
- Cancers of the head or neck
- Leukemia, lymphoma
- Silicosis/Pulmonary Fibrosis
- Underweight or malnourished
- Previous positive TB skin test or blood test

❑ **Yes** ❑ **No** **Section 4: Check if you have lived in or traveled to any country in the following areas of the world for a duration of 3 months or more within the past 5 years:**

- Africa
- Asia
- Central America, including Mexico
- India and other Indian Subcontinent nations
- Eastern Europe
- Middle East
- South America
- Caribbean{except Jamaica, Saint Kitts and Nevis, Saint Lucia, Virgin Islands (USA)}

Country of birth: _____

U.S. arrival date: _____

Lived or traveled to what country: _____

Length of time: _____

Date of Travel: _____

_____

To be completed by health care provider if TB risk factors listed in 1 or more sections above {TB skin test or IGRA blood test is required}. Prior BCG vaccine does not exempt student from TB testing.

1. Tuberculin Skin Test (must be placed on or after **June 15** for fall semester or **November 1** for spring semester)
   Date applied:_____ Date read:_____ Result (millimeters of induration):_____
   Interpretation (based in mm of induration as well as risk factors) ❑ Positive ❑ Negative

2. Interferon Gamma Release Assay (IGRA) drawn on or after **June 15** for fall semester or **November 1** for spring semester. Attach report
   Date obtained: _____ Specify method: ❑ QTF-G ❑ QTF-GIT ❑ T-Spot
   Result: Negative_____ Positive_____ Indeterminate _____ Borderline _____

3. Chest X-Ray (required on or after **June 15** for fall semester or **November 1** for spring semester if Tuberculosis Skin test or IGRA listed above is positive)
   Date of chest x-ray:_____ Result: ❑ Normal ❑ Abnormal
   INH Initiated: ❑ Yes ❑ No If yes, Date Initiated:_____

4. History of past positive PPD or IGRA (please circle):
   Date of positive PPD/IGRA:_____ Date INH completed:_____
   INH not initiated (chest x-ray required on or after **June 15** for fall semester or **November 1** for spring semester) Date of x-ray_____ Result: ❑ Normal ❑ Abnormal

Healthcare Provider signature: _____ Date:_____

Healthcare Provider address and clinic stamp: _____

SUBMIT THIS FORM WITH YOUR IMMUNIZATION DOCUMENTATION

Part C. To be completed and signed by a health care provider (except Meningococcal and Hepatitis B waivers)

Student's Name_____ UIN _____

Required Immunizations

1. Meningococcal Vaccine (Given on or after the 16th birthday) _____ Vaccine used: ❑ Menactra ❑ Menomune ❑ Menveo
Month Day Year

or signed Waiver (see below). Vaccine information on SHS website.

WAIVER: I have been fully informed of the risks and health hazards of meningococcal infection as well as the benefits of the Meningococcal vaccine. I choose not to be immunized against meningococcal infection.

Student signature (parent/legal representative if under age 18):_____

2. M.M.R. (Measles, Mumps, Rubella) Age exempt for measles/mumps/rubella? Yes____ No____
(after 1st birthday and after May 1971) (Born before 1957)

Dose 1: _____
Month Day Year

Dose 2: _____
Month Day Year

OR INDIVIDUAL VACCINES

Measles
(2 doses not prior to 1968)
Dose 1: _____
Month Day Year
Dose 2: _____
Month Day Year

Mumps
(2 doses not prior to June 1969)
Dose 1: _____
Month Day Year
Dose 2: _____
Month Day Year

Rubella
(1 dose not prior to June 1969)
Dose 1: _____
Month Day Year

or Attach laboratory proof of immunity to all 3 diseases.

3. Tetanus-Diphtheria
(Within last 10 years)
_____
Month Day Year

OR

Tdap
(Within last 10 years)
_____
Month Day Year

4. Polio (Series Completed)
_____
Month Day Year

5. Hepatitis B: Completed series? Yes___ No___ Dates: 1)____/____/____2)____/____/____3)____/____/____
or Merck 2 dose adolescent series: Dates: 1)____/____/____2)____/____/____

or signed Hepatitis B Waiver (see below) Vaccine information available on SHS website.

WAIVER: I have been fully informed of the risks and health hazards of hepatitis B infection as well as the benefits of the hepatitis B vaccine. I choose not to be immunized against hepatitis B infection.

Student signature (parent/legal representative if under age 18):_____

HEALTH CARE PROVIDER

I have reviewed the immunization records of this patient and certify that the entries above are correct.

_____ _____ (_____)_____
Signature of Health Professional Date Telephone

_____ _____
Printed Name of Health Professional Office Address and Clinic Stamp

Medical Exemption from Immunization Requirement
The physical condition of the above-named individual is such that immunization would endanger life or health.
Condition:_____

Exemption: Permanent_____ Temporary (Exemption Expires on) _____

Signature and Title of Medical Provider_____ Date_____

Religious Exemption from Immunization Requirement (TB screening is still required)
A notarized letter from spiritual leader is required or CRE – 1 form from Virginia Department of Health. I adhere to a religious belief whose teachings are opposed to immunization. By Refusing to be immunized, I realize that I will be excluded from classes and required to leave the campus during an outbreak of communicable disease, as determined by the campus health officials. I release Old Dominion University and its employees from responsibility for any impairment to my health resulting from this exemption.

Signature _____ Date _____