BLUEFIELD COLLEGE

Bluefield College

HEALTH INFORMATION PACKET

2015 Academic Year

HEALTH INFORMATION PACKET CHECKLIST

This health information is required of all new students.

Congratulations on your acceptance to Bluefield College! Prior to your enrollment, information about **your health and immunization status is required by College policy and Virginia law** to be submitted to the Office of Student Development.

Please use the checklist below to ensure that all the necessary details for your Health Information Packet have been completed and are included. Your completed Health Information Packet must be **submitted to the Admissions Office or Student Development by 5 pm on August 1st for students entering in the *Fall Semester* and by 5 pm on January 2nd for students entering in the *Spring Semester***.

☐ Complete *Health Information Packet* including:

- up-to-date immunization/screening information, including:
- records and appropriate boosters for required childhood immunizations, including two (2) doses of MMR (measles, mumps and rubella), a tetanus booster within the past ten (10) years, and a TB screening or skin test on or after March 1, 2013
- records (or appropriate waiver forms) for required additional immunizations and screenings for both Hepatitis B and Meningococcal Disease
- immunization record for ACHA-recommended Varicella (chicken pox) vaccine,
- full insurance information, including signature of policyholder/carrier
    - Please check our website for current information concerning our student health insurance requirement, the hard waiver process, and open enrollment timeframes. All Bluefield College students who are enrolled in a minimum of 6 credit hours per semester and in a degree-seeking program are required to complete an on-line waiver.
- student signature
- legal guardian signature for minor students

☐ Complete *Medical Consent for Minor Students Form (if applicable)*

☐ Provide proof of insurance; all students are required to have health insurance and must provide complete insurance information ***and*** a copy of the card (front/back)

☐ Retain a copy of the Health Information Packet for your records

Failure to return the completed Health Information Packet will prevent a student from registering for classes.

Please return the completed Packet to the address or submit online. Please do not enclose it with other College correspondence to ensure that it reaches the Office of Student Development in a timely manner. For additional information or if you have questions, please contact us at 276.326.4207.

Students: Please answer ALL questions (type or print in black ink only). This information will become part of your confidential records accessible only to appropriate College personnel. Failure to complete and return this form to the above address by August 1 for fall semester (January 2 for spring semester entry) will prevent registration for classes.

PERSONAL DATA

Name _____ _____ _____ SSN *XXX - XX* - ____ ____ ____ ____
Last First M. I. (last four digits only)
Home address _____
PO Box/Street Address
_____
City State Zip code
Telephone ( ) _____ home; ( ) _____ cell Birthdate _____ /_____/_____ Sex ___Male ___ Female

EMERGENCY CONTACTS

Please include at least one contact who does not live at your permanent residence.

1. Name _____ Relationship _____
Last First
Home address _____
PO Box/Street Address
_____
City State Zip code
Telephone ( ) _____ home; ( ) _____ work; ( ) _____ cell

2. Name _____ Relationship _____
Last First
Home address _____
PO Box/Street Address
_____
City State Zip code
Telephone ( ) _____ home; ( ) _____ work; ( ) _____ cell

CURRENT HEALTH INFORMATION

Do you have any allergies? ☐ No ☐Yes, please check applicable boxes below & specify in the space provided.

☐ Medications_____ ☐ Insect venom _____
☐ Foods _____ ☐ Pollens/dusts/molds _____
☐ Other _____

Are you currently taking any medications (birth control, allergy, acne, etc.)? _ No _ Yes, please detail below.
Drug _____ / dose _____ / reason _____
Drug _____ / dose _____ / reason _____
Drug _____ / dose _____ / reason _____
Drug _____ / dose _____ / reason _____
Drug _____ / dose _____ / reason _____
Drug _____ / dose _____ / reason _____

Do you have any current, recent or past health problems, hospitalizations, surgeries, or injuries? _ No _ Yes, please detail below.
_____
_____
_____

MENTAL HEALTH HISTORY

Please answer all questions. If "yes," additional information required (medications, reasons for medication, dates, place/duration of treatment, etc.).

Have your academic and/or work activities ever been interrupted because of mental or emotional problems? ☐No ☐ Yes, explain.

_____

Have you ever been treated with any medication for psychiatric reasons? ☐No ☐ Yes, explain.

_____

Have you ever been hospitalized for mental or emotional problems? ☐No ☐ Yes, explain.

_____

IMMUNIZATIONS/SCREENINGS

The immunizations/screenings listed below are required by Virginia law. The signature of your health care professional must accompany this information.

Please check the appropriate box (check only one):

☐ Attached is a **copy** of my immunization record.
Proceed to Tuberculosis Screening Form and Insurance Information section.

☐ Attached is a copy of my immunization/screening documentation, including the signature of my health care professional. *(a signature of a health care professional, complete with telephone number, address, etc. if the information has been recorded rather in handwritten)*

Proceed to Tuberculosis Screening Form and Insurance Information section.

Required childhood immunizations

DPT (Diphtheria/Pertussis/Tetanus) Series
Dates received: 1st _____; 2nd _____; 3rd _____; Booster _____

IPV/OPV (Polio) Series
Dates received: 1st _____; 2nd _____; 3rd _____; Booster _____;

MMR (Measles/Mumps/Rubella) Series
Dates received: 1st _____; 2nd_____;*Must have received two doses if born after 1957.*

Other required immunizations & screenings

Tetanus *Must have been received within 10 years of registration.*
Date received: _____

PPD/TB Test or Screening *Must be completed on or after March 1, 2013.*

Screening date: _____ **Results:** ☐No test required; form required ☐Test required

Test date: _____ **Results:** ☐Negative ☐Positive - chest x-ray required

Meningococcal (Meningitis) Vaccine *The risk of meningococcal disease may be increased in some subsets of college students. The American College Association recommends you receive this vaccination. In accordance with Virginia law, students who do not receive this vaccination are required to complete the enclosed waiver. Meningococcal meningitis vaccine is required by Virginia law for all new undergraduates unless a waiver is signed. The waiver and frequently asked questions are available at* http://www.cdc.gov/vaccines/spec-grps/college.htm

Date received: _____ **Not received:**☐ Completed waiver enclosed

Hepatitis B Vaccine *In accordance with Virginia law, students who do not receive this vaccination are required to complete the enclosed waiver. Hepatitis B vaccine is required by Virginia law for all new undergraduates unless a waiver is signed. The waiver and frequently asked questions are available at http://www.cdc.gov/vaccines/spec-grps/college.htm*

Date received: _____ ☐ Completed waiver enclosed

Recommended Varicella (Chicken Pox) Vaccine *Based on guidelines from the American College Health Association (ACHA),* **immunization** *this immunization is recommended but not required. Consult your health care professional with questions.*

Varicella diagnosis: Date_____ **OR Vaccine:** ☐ Date rec'd _____ ☐ Not taken

Required Signature Health Professional Signature
_____ **Date** _____

INSURANCE INFORMATION

Bluefield College is committed to ensuring that all students have access to affordable, quality, and comprehensive health insurance. The Student Health Insurance Plan offered through Bluefield College was selected carefully after reviewing the options and cost of plans available. We have worked very hard to achieve the lowest cost health insurance without greatly affecting the quality of the benefits currently offered in the plan.

Bluefield College practices a "hard waiver" insurance plan. This simply means that every student is required to show proof of health insurance. Students are automatically billed a six (6)-month premium for Student Health Insurance to their student account. Each student must prove that they have coverage each semester by completing and submitting an on-line waiver before the deadline or this premium will be NOT removed from their account. *ALL students are required to prove their health insurance coverage*. They will need to complete an on-line waiver at the beginning of each academic year.

If students would like to enroll in the Student Health Insurance Plan, instructions are provided through student email, the parent club, Office of Student Development and the student insurance website. Students are encouraged to contact the Office of Student Development with questions about waiving or enrolling in the student insurance. The 2014-2015 AIG benefit flyer highlights and gives an overview of coverage. You may read more by going to the website and viewing the extensive details about the insurance and how you can manage your plan. Any late arrangements to petition to waive made with Bluefield College will be subject to a late administrative fee of $50.

Cost and details of the policy plan are available online. *All students are required to have health insurance – full information below and a copy of the card (front/back) must be on file.*

Insurance Company: Name _____ Policy Number _____
Address _____ Group Number _____
City/State Zip _____ Telephone Number _____
Policyholder: Name _____ Employer _____
Last 4 digits of Social Security Number _____ ☐ Required copy of card front/back enclosed

I hereby assign the benefits of my insurance policy to Bluefield College designated health care provider, as appropriate. I understand that I am responsible for all charges that are not paid by that policy. I authorize the release of information needed to my insurance company in order to consider payment of my claim for services rendered. I understand that this assignment and authorization will remain in effect indefinitely or until such time that I give written notice to the contrary.

Policyholder signature _____Date _____

STUDENT and/or PARENT/GUARDIAN SIGNATURE(S)

My signature below indicates that the information provided on this form is accurate and complete, and that all immunizations and required screenings/tests have been correctly and truthfully recorded. I also understand that my signature signifies permission for the release of medical information to appropriate College personnel.
Student signature *(full name)* _____ Date _____
Parent/guardian signature of a minor student *(full name)* _____ Date _____

A record of a Tuberculosis Screening is required for all students enrolled at Bluefield College. Students may submit the information in one of two ways:

1. Submit this form which has been completed and signed by your health care professional OR 2. Have your health care professional complete and sign the appropriate section on the College's Pre-Entrance Health Form.
Name _____ _____ _____ SSN *XXX-XX-* __ __ __ __
Last First M. I. (last four digits only)

THIS SECTION TO BE COMPLETED BY YOUR HEALTH CARE PROFESSIONAL

The American College Health Association has published guidelines on tuberculosis screening of college and university students. Bluefield College has adopted these guidelines based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org , www.cdc.gov/tb/default.htm or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments.

Please complete this form for the student designated above:

1. Does the student have signs or symptoms of active TB disease?

   ☐NO proceed to question 2

   ☐YES proceed with additional evaluation to exclude active TB disease, including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group1 (see below) or is the student entering the health profession?

   ☐NO stop, no further evaluation is needed at this time; screening is complete.

   ☐YES place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified Protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermal into the volar (inner) surface of the forearm). A history of BCG vaccination should not preclude testing of a member of a high-risk group. If PPD is not placed, a chest x-ray is required (see #4 to record x-ray results).

3. Tuberculin Skin Test (must have been placed on or after March 1, 2013)
   Date given: _____ Date read: _____
   Result: _____ (record actual mm of induration, transverse diameter; if no induration, write "0").

   Interpretation (based on mm of induration, as well as risk factors): ☐negative ☐positive

4. Chest x-ray (required if tuberculin skin test is positive or if PPD has not been placed for any reason; must have been performed on or after March 1, 2013)

   Date of x-ray: _____ Result: ☐normal ☐ abnormal

Health Care Professional:

Name _____ Address _____
Telephone _____ _____
Signature _____ Date _____

Categories of high-risk students include those students who have arrived within the past five (5) years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, student should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Lusembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection; who inject drugs; who have resident 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, leukemia's or lymphomas, low body weight, gasterectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone greater than or equal to 15 mg/d for greater than or equal to one month) or other immunosuppressive disorders.

RELEASE OF MEDICAL INFORMATION

As a student of Bluefield College, I realize that it is possible for a medical emergency to occur. Therefore, I am giving the Student Development or his/her designee permission to release the medical information listed below to the appropriate officials (i.e. Residence Life staff and Campus Police). I understand that my records will be kept confidential at all times by these officials.

Print Name

Student Signature *Date*

Parent/legal guardian signature of minor student *Date*

MEDICAL CONSENT FOR MINOR STUDENTS

I, the parent/legal guardian of _____(full student name), give permission for the Office of Student Development and to Bluefield College and/or designated health care provider(s) or his/her designee, and/or the Emergency Department personnel of College's designated health care provider to provide medical assistance to my son/daughter who is under 18 years of age, and is therefore legally a minor. I also give you permission of contact the person listed below in the event that I cannot be reached.

Full name of parent/legal guardian _____

Relationship to student _____

Street Address/PO Box _____City _____ State _____

Zip _____ Telephone numbers (h) _____(w)_____(c)_____

Parent/legal guardian signature _____ Date _____

Full name _____ Relationship to student _____

Street Address/PO Box _____City _____ State _____

Zip _____ Telephone numbers (h) _____(w)_____(c)_____

The Office of Student Development may provide medical assistance, provide over-the-counter medication and/or personal counseling by a professional counselor. Bluefield Regional Medical Center is the current contracted health provider.

HEPATITIS B & MENINGOCOCCAL IMMUNIZATION WAIVER FORMS

Office of Student Development, Bluefield College, 3000 College Drive, Bluefield Virginia 24605

WAIVER OF IMMUNIZATION AGAINST HEPATITIS B

The Code of Virginia (Chapter 340 23-7.5) requires that "All full time students, prior to enrollment in any public four year institution of higher education, shall be vaccinated against Hepatitis B." Institutions of higher education must provide the student or the student's parent or other legal representative detailed information on the risks associated with the Hepatitis B, and on the availability and effectiveness of any vaccine. The Code permits "the student or if the student is a minor, the student's parent or the legal representative to sign a written waiver stating that he/she has received and reviewed the information on Hepatitis B and detailed information on the risks associated with the Hepatitis B and on the availability and the effectiveness of any vaccine, and has chosen not to be or not have the student vaccinated." I have read the Hepatitis B Frequently Asked Questions at www.cdc.gov/ncidod/diseases/hepatitis/b/faqb.htm , and reviewed the risks associated with the disease, including the effectiveness and availability of any vaccine against Hepatitis B.
I choose not to be vaccinated against Hepatitis B.

Print Name

Student Signature *Date*

_____ **XXX-XX-**____ ____ ____ ____
Date of Birth *Student social security number (Last 4 digits only)*

Parent/legal guardian signature of minor student *Date*

WAIVER OF IMMUNIZATION AGAINST MENINGOCOCCAL DISEASE

The Code of Virginia (Chapter 340 23-7.5) requires that "All full time students, prior to enrollment in any public four year institution of higher education, shall be vaccinated against Meningococcal Disease." Institutions of higher education must provide the student or the student's parent or other legal representative detailed information on the risks associated with the Meningococcal Disease, and on the availability and effectiveness of any vaccine. The Code permits "the student or if the student is a minor, the student's parent or the legal representative to sign a written waiver stating that he/she has received and reviewed the information on Meningococcal Disease and detailed information on the risks associated with the Meningococcal Disease and on the availability and the effectiveness of any vaccine, and has chosen not to be or not have the student vaccinated."

I have read the Meningococcal Disease Frequently Asked Questions at www.cdc.gov/meningitis/about/faq.html , and reviewed the risks associated with the disease, including the effectiveness and availability of any vaccine against Meningococcal Disease.

I choose not to be vaccinated against Meningococcal Disease.

Print

Student Signature *Date*

_____ XXX-XX-____ ____ ____ ____
Date of Birth *Student social security number (Last 4 digits only)*

Parent/legal guardian signature of minor student *Date*