



## Mary Baldwin College Health Record/Form

Commonwealth of Virginia Law and/or Mary Baldwin College requires that the Health Record/Form and Immunization Record be completed and submitted to the College for both residential and commuter students to matriculate and begin classes. Your cooperation is appreciated.

**ALL DOCUMENTATION, including IMMUNIZATION RECORD is to be  
SUBMITTED by August 1, 2011 for Fall 2011.**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle MM/DD/YYYY

Social Security # \_\_\_\_\_ Marital Status: ( ) Single ( ) Married ( ) Divorced

Home Phone: ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ MBC Email: \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Parent/Guardian Home # ( ) \_\_\_\_\_

Class Entering: ( ) Freshman ( ) Transfer Parent/Guardian Cell # ( ) \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City State Zip

In case of Emergency, Notify \_\_\_\_\_  
Name Day/Work # Home# Relationship

### **PROOF OF HEALTH INSURANCE**

Insurance Company \_\_\_\_\_  
Insurance Subscriber Name \_\_\_\_\_  
Insurance Policy # \_\_\_\_\_  
Insurance Company's Telephone Number ( ) \_\_\_\_\_

Please submit a copy of your valid insurance card.

### **PERMISSION FOR TREATMENT**

The College reserves the right to have any student admitted to the College examined by the College Physician/Nurse Practitioner. This form must be signed by the student. If the student is a minor (under 18 years), this form must also be signed by the parent or legal guardian so that appropriate diagnosis and treatment may be promptly carried out.

I certify that the information provided is true and complete to the best of my knowledge. I also understand that the information that I have provided in the health record will be reviewed by the **Health Center, Counseling and Psychological Services, and Head Athletic Trainer** (\*if applicable).

I give permission to the College to furnish such procedures as may be deemed necessary by the **Health Center staff/Counseling and Psychological Services Staff /Head Athletic Trainer** (\*if applicable) on my daughter's behalf.

Student signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_ Relationship \_\_\_\_\_

## PERSONAL HEALTH HISTORY

*Please circle to indicate if you have ever been or are now being treated for the following:*

ADD/ADHD	FRACTURE
AIDS/HIV	HEART CONDITION
ALCOHOLISM	HEPATITIS/LIVER DISEASE
ALLERGIES/HAY FEVER	HERPES
ANEMIA	HYPERTENSION (High Blood Pressure)
ANXIETY	HYPOGLYCEMIA (Low Blood Sugar)
ASTHMA	IRRITABLE BOWEL SYNDROME
BLOOD DISORDERS	MIGRAINE HEADACHES
CANCER	MONONUCLEOSIS
CEREBRAL PALSY	MULTIPLE SCLEROSIS
CYSTIC FIBROSIS	ORGAN TRANSPLANT
CHRONIC BRONCHITIS	PELVIC INFECTION
CHRONIC KIDNEY CONDITION	PHLEBITIS
CHRONIC INFLAM. BOWEL DISEASE	RHEUMATIC FEVER
CROHN'S DISEASE	RHEUMATOID ARTHRITIS
DENTAL DISEASE	SEIZURE DISORDER
DERMATOLOGICAL DISORDERS	SEXUALLY TRANSMITTED DISEASE
DEPRESSION	STOMACH PROBLEMS/PEPTIC ULCER
DIABETES	SYSTEMIC LUPUS ERYTHEMATOSUS
DRUG DEPENDENCY	THYROID DISORDER
DYSMENORRHEA	TUBERCULOSIS
EATING DISORDER	URINARY TRACT INFECTION
OTHER: _____	

*Give details regarding any condition you marked above:*

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## FAMILY HISTORY

*Please circle to indicate if the condition exists in your family (includes parents, siblings, & grandparents):*

ASTHMA	MENTAL ILLNESS
BLEEDING/CLOTTING DISORDERS	RESPIRATORY PROBLEMS
CANCER	RHEUMATIC FEVER
DIABETES	STROKE
EYE DISORDERS	TUBERCULOSIS
HEART DISEASE	OTHER: _____
BLOOD PRESSURE	HIGH

## ADDITIONAL INFORMATION

*Answer the following questions.*

**ALLERGIES:** Medications, Foods, Environmental, Seasonal, etc. (\* please list) \_\_\_\_\_

**HOSPITALIZATIONS:** Yes \_\_\_ No \_\_\_ (\* if yes, please provide details) \_\_\_\_\_

**SURGERIES:** Yes \_\_\_ No \_\_\_ (\* if yes, please provide details) \_\_\_\_\_

**MEDICATIONS:** Yes \_\_\_ No \_\_\_ (\* if yes, list drug name & dosage currently taken) \_\_\_\_\_

Do you have a medical condition, which might interfere with eating in the College dining hall? (\* special diets cannot be supplied) Yes \_\_\_ No \_\_\_ If yes, please specify: \_\_\_\_\_

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle MM/DD/YYYY

### MENTAL HEALTH INTERVENTIONS

Have you ever had any treatment or counseling for any emotional, behavioral or psychological condition? Yes\_\_\_ No\_\_\_

Have you ever been treated with any medication for psychiatric reasons? Yes\_\_\_ No\_\_\_

Have you ever been diagnosed with or treated for ADD or ADHD? Yes\_\_\_ No\_\_\_

If the answer to any of the above questions is yes,

- A full report from your physician, psychiatrist, certified therapist, or counselor is required before registration.
- The full report will include a statement of the problem (diagnosis), treatment, response to treatment, and need for follow up.
- This report should be directed to the college Health Center, Head Athletic Trainer and Counseling and Psychological Services.
- This report will not be released without the written consent of the student.

### SPECIAL NEEDS

Do you consider yourself handicapped or disabled in any way that requires you to receive special consideration from the college? ( ) No ( ) Yes

If so, please give details below:

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The Health Center works in cooperation with the Office of Student Life in attempting to meet the needs of students with special needs.

***Would you object if the Health Center referred your name to:***

Office of Dean of Students? ( ) No ( ) Yes  
Director of Learning Skills Center? ( ) No ( ) Yes





# IMMUNIZATION RECORD - PUBLIC HEALTH REQUIREMENTS

Virginia Code (Sec. 23-7.5) requires students attending Mary Baldwin College to provide documentation of their immunizations by a licensed health professional. All information must be documented in the English language.

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle MM/DD/YYYY

### REQUIRED:

**M.M.R. (Measles, Mumps, and Rubella) - \*Two doses required.**  
 Dose # 1 given at age 12-15 months or later .....#1 \_\_\_/\_\_\_/\_\_\_  
 Dose #2 given at age 4-6 years or later and at least one month after first dose. #2 \_\_\_/\_\_\_/\_\_\_

**TETANUS-DIPHTHERIA**(Primary series with DtaP or DTP and booster with Td in the last ten years meets requirement. Refer to ACIP for details.)  
 Primary series of four doses with DtaP or DTP: **Date series completed:** \_\_\_/\_\_\_/\_\_\_  
 Tetanus-Diphtheria (TD) booster within the last ten years: ..... \_\_\_/\_\_\_/\_\_\_

**POLIO** (Primary series in childhood meets requirement; three primary series schedules are acceptable. Refer to ACIP for details) Date series completed: \_\_\_/\_\_\_/\_\_\_

**TUBERCULOSIS SCREENING (\*PPD required regardless of prior BCG inoculation.)**  
 PPD (Mantoux) within the past 12 months (*tine or monovac not acceptable*)  
 Date Given: \_\_\_/\_\_\_/\_\_\_ Date Read: \_\_\_/\_\_\_/\_\_\_ Result: Neg \_\_\_ Pos \_\_\_  
*\*If positive, \_\_\_\_\_ mm induration (horizontal diameter)*

- If PPD is positive, chest x-ray required. **X-ray results** \_\_\_Normal \_\_\_Abnormal  
**Date of x-ray:** \_\_\_/\_\_\_/\_\_\_

### RECOMMENDED:

**VARICELLA:** History of chicken pox or two doses of vaccine? ( ) No ( ) Yes *If yes, what age?* \_\_\_\_\_  
 Immunization  
 Dose #1 \_\_\_/\_\_\_/\_\_\_ Dose #2 \_\_\_/\_\_\_/\_\_\_ (given at least one month after 1<sup>st</sup> dose if age 13 years or older)

**HEPATITIS B:** Three doses of the vaccine are required to complete series.  
 Dose #1 \_\_\_/\_\_\_/\_\_\_ Dose #2 \_\_\_/\_\_\_/\_\_\_ Dose #3 \_\_\_/\_\_\_/\_\_\_

**INFLUENZA:** (Annual immunization in Fall is recommended to avoid disruption to academic activities.)  
 Date vaccinated: \_\_\_/\_\_\_/\_\_\_

**MENINGOCOCCAL:** One dose, *highly recommended*, preferably at entry into college for freshman living in dormitories or residence halls who wish to reduce their risk of contracting meningitis.  
 Quadrivalent polysaccharide vaccine: \_\_\_/\_\_\_/\_\_\_

