Student Name _____ Date of Birth _____

Northern Vermont UNIVERSITY | LYNDON

NVU-Lyndon Health Form

RETURN TO:

NVU-Lyndon Health and Counseling Center
1001 College Rd.
PO Box 919
Lyndonville, VT 05851
802.626.6440 (p)
802.626.6387 (f)

Northern Vermont University-Lyndon Student Health Form

Please return the completed Student Health Form (including your immunization history), the Documentation of Varicella (Chickenpox) Disease if applicable, and a copy of your insurance card (front and back) to the NVU-Lyndon Health and Counseling Center.

Important Deadlines

August 1 for August entry (Fall semester), **January 1** for January entry (Spring semester)

LyndonHealth@NorthernVermont.edu

Instructions

This form must be completed, signed, and submitted in order for you to register for classes. The physical examination and immunization history **must be completed and signed by your health care provider.**

Name _____

Preferred Name _____

Date of Birth _____

Gender _____

Preferred Pronoun _____

Student ID _____

Program of study _____

Permanent address

_____

_____

Telephone

Home number _____ - _____ - _____

Cell number _____ - _____ - _____

Work number _____ - _____ - _____

NO HEALTH INSURANCE? Check Here _____

If you do not have Health Insurance and are a full-time student you will be required to purchase the Vermont State College System's student health insurance policy.

Health Insurance Company - Provide Copy of Insurance Card with Form

_____

Policy number _____

Group number _____

Person to notify in case of emergency

Name _____

Relationship _____

Address

_____

_____

_____

Telephone

Home phone _____ - _____ - _____

Cell phone _____ - _____ - _____

Work phone _____ - _____ - _____

My signature below indicates that:

> I consent to medical and nursing treatment by the health center staff.
> The information on this form is correct and complete to the best of my knowledge.
> I understand that my contacts with health and counseling services are held in confidence, but that confidentiality may be broken if a life is in danger.

Student signature _____ Date ____ / ____ / ____

Parent/Guardian signature _____
(Required if student is under 18 or if insurance is in parent's or guardian's name.)

Student Medical History

To be reviewed by healthcare provider

Student Name _____ Date of Birth _____

Allergies **No** ☐ **Yes** ☐ (yes, list known allergies and type of reaction.)

Medication

Food/Environmental

Medications

List all medications taken regularly. Include prescription, non-prescription medications, birth control, vitamins, minerals, and supplements.

Hospitalizations

No ☐ **Yes** ☐ Have you ever been hospitalized for any surgical or medical or psychiatric illness?
If yes, specify diagnosis and date:

Counseling

No ☐ **Yes** ☐ Have you received counseling or psychiatric care?
If yes, please specify:

Do you have or have you previously had the following

(Check those that apply; if yes, explain.)

- ☐ Anemia or other blood disorder
- ☐ Asthma
- ☐ ADHD (Attention Deficit Disorder)
- ☐ Bleeding disorder
- ☐ Breast abnormality
- ☐ Broken bone
- ☐ Cancer
- ☐ Chickenpox
- ☐ Concussion/head injury
- ☐ Counseling help
- ☐ Diabetes
- ☐ Eye problems
- ☐ Ears/nose/throat problems
- ☐ Eating disorder
- ☐ Frequent ear infections
- ☐ Fainting
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart problem
- ☐ Hepatitis/liver disease
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Joint or limb problem
- ☐ Kidney/bladder problems
- ☐ Marijuana
- Other drug use
- ☐ Menstrual problems
- ☐ Mental health issues (anxiety, depression)
- ☐ Missing organ
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Musculoskeletal injury
- ☐ Orthopedic Problems
- ☐ Overweight
- ☐ Pneumonia
- ☐ HIV/AIDS
- ☐ Seizure or epilepsy
- ☐ Sickle cell disease or trait
- ☐ Skin problems
- ☐ Stomach or intestinal problems
- ☐ Thyroid disorder
- ☐ Tobacco use
- ☐ Tuberculosis or positive TB test
- ☐ Underweight
- ☐ Urinary tract infection
- ☐ Consume alcohol

Explain

Family History

Parents, siblings, grandparents (check all that apply). If adopted and history is unknown, select here: ☐

	Yes	No	Relationship		Yes	No	Relationship
Diabetes				Cancer (type:)			
High Blood Pressure				Sickle Cell Anemia			
Stroke				Thyroid Disease			
High Cholesterol				Depression / Mental Illness			
Heart Attack Before 55				Liver Disease			
Alcoholism				Other serious illness			

If either parent or a sibling is deceased, list relationship to you, age at death, and cause of death:

Comments

Student Signature _____ Date ____ / ____ / _____

Signature of Person Completing Form _____ Date ____ / ____ / _____
(If other than student.)

Reviewed by Health Care Provider Yes ☐ Date ____ / ____ / _____

Student Name _____ Date of Birth _____

Physical Form

To Be Completed By Health Care Provider

Date of Exam ___/___/_____

Name of student _____ (Within past 12 months.) Date of birth ___/___/_____
LAST FIRST MI

Height _____ BP _____ Vision uncorrected: R _____ L_____

Weight _____ Pulse _____ Vision corrected: R _____ L _____

NORMAL	ABNORMAL		PLEASE COMMENT ON ABNORMAL ITEMS
☐	☐	General Development	
☐	☐	Head, face, scalp, skull	
☐	☐	Eyes	
☐	☐	Ears, Nose/Sinus, Throat	
☐	☐	Neck, Thyroid	
☐	☐	Heart	
☐	☐	Lungs	
☐	☐	Breasts	
☐	☐	Abdomen (include hernia)	
☐	☐	Genitals (incl. testicular exam)	
☐	☐	GYN (if indicated)	
☐	☐	Extremities	
☐	☐	Musculoskeletal	
☐	☐	Lymph glands	
☐	☐	Neurological	
☐	☐	Skin	

If yes, please comment below.

No ☐ Yes ☐ Is the student receiving medical care for a chronic condition or serious illness?

No ☐ Yes ☐ Do you have any concerns about the student participating in competitive physical activity?

No ☐ Yes ☐ Do you feel that there are any mental or emotional concerns to be aware of?

Comments

Health care provider signature _____ Date ___ / ___/ _____

Health care provider printed name _____

Provider address, phone and fax _____

_____

Student Name _____ Date of Birth _____

Vaccines and Immu-nizations

To Be Completed By Health Care Provider

Vermont State Law requires proof of vaccinations OR documented disease OR a positive titer. You may not register for classes until completed Health Forms and immunization is received by the college Health Center.

Required Immunizations

MMR (Measles, Mumps, Rubella)

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

OR

Measles Titier Date ____ / ____ / _____

Mumps Titier Date ____ / ____ / _____
(Attach copy of lab reports)

Rubella Titier Date ____ / ____ / _____

Rabies Vaccine Series (for Vet Tech Students)

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

Date 3 ____ / ____ / _____

Polio Vaccine Series (for all Nursing Students)

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

Date 3 ____ / ____ / _____

Polio Titer

Date 1 ____ / ____ / _____
(Attach copy of all lab reports)

Td (Tetanus/Diphtheria)

Date ____ / ____ / _____

OR

Tdap (Tetanus/Diphtheria/Pertussis)

Date ____ / ____ / _____

Hepatitis B Series

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

Date 3 ____ / ____ / _____

Varicella (Chicken Pox)

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

OR

Date of Disease ____ / ____ / _____

OR

Date of Titer ____ / ____ / _____
(Attach copy of lab report or required documentation form)

Meningococcal

Date ____ / ____ / _____

Tuberculosis Screening

1. Has the student lived outside the following countries: No ☐ Yes ☐
   USA, Canada, Jamaica, Virgin Islands, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, UK, Samoa, Australia, New Zealand, Saint Lucia, Saint Kitts and Nevis.
2. Has the student been in close contact with someone with tuberculosis? No ☐ Yes ☐
3. Has the student resided or worked in a prison, homeless shelter, nursing home, or hospital? No ☐ Yes ☐
4. Does the student have cancer, leukemia, diabetes, HIV/AIDS, history of IV drug use or take immunosuppressive medication such as prednisone? No ☐ Yes ☐

If any answers were YES, PPD skin test is required.

Date given ____ / ____ / _____

Date read ____ / ____ / _____

Result ____ / ____ / _____

Chest x-ray

(Required if tuberculin skin test is positive.)

Abnormal ☐ Normal ☐

Date ____ / ____ / _____

Health care provider signature _____ Date ___ / ___ / _____

Health care provider printed name _____

Provider address, phone and fax _____

_____

Academic Year 2020-21
Immunization Entry
Requirements

VERMONT
DEPARTMENT OF HEALTH

Vermont's Immunization Rule applies to all full-time undergraduate students, and any student enrolled in an allied health science program.

Upon matriculation an official immunization record must be presented to the student health center. Students can obtain these records from primary care provider's offices, previously attended schools, or State Immunization Registries. Failure to submit necessary documentation may delay registration for classes.

Students must provide documentation of the following vaccinations:

- 1 dose of Tdap (tetanus, diphtheria and pertussis) vaccine
- 2 doses of MMR (measles, mumps and rubella) vaccine
- 3 doses of hepatitis B vaccine
- 2 doses of chickenpox (varicella) vaccine. If the student has previously had chickenpox disease no vaccine or exemption is needed. Submit documentation of disease or sign the Health Department form
- 1 or 2 doses of quadrivalent meningococcal conjugate vaccine (MenACWY). This requirement is for first year students living in dormitories who are younger than age 22. Only those vaccinated before their 16th birthday need a second dose before college entry.

In the past 20 years, the overall incidence of meningococcal disease has decreased 10 - fold, due in part to the effectiveness of the meningococcal conjugate vaccine (MenACWY), recommended by the Centers for Disease Control and Prevention (CDC) since 2005. However, serogroup B is now the primary cause of meningococcal disease and outbreaks in young adults. Although a vaccine specific to serogroup B (MenB) is available, it isn't routinely recommended or required at this time. Students should review the need for MenB vaccine with their primary care provider.

An exemption for one or more immunizations based on medical or religious reasons is allowed under the rule. An exemption form must be completed and submitted in lieu of vaccination records to the student health center. This form is available at the Health Department's website: http://www.healthvermont.gov/immunizations-infectious-disease/immunization/k-12-school-nurses-and-administrators

VERMONT
DEPARTMENT OF HEALTH

Documentation of Varicella (Chickenpox) Disease

Vermont's Immunization Rule applies to any child or student attending any center-based or family child care facility, public or independent kindergarten, elementary and secondary schools, and undergraduates enrolled in colleges and universities. Before entry, children/students must have the required immunizations unless exempt for medical or religious reasons.

Before entry, all vaccine requirements must have been met, including two doses of varicella (chickenpox) vaccine. However, for those with a history of chickenpox disease, neither a vaccine nor an exemption is needed. This form (or other documentation such as a signed statement, or notation in an Immunization Registry or other health record) may be submitted to the child care program, school or college in lieu of vaccination. The signature of a health care practioner is not needed.

Complete all information below on behalf of the child/student named. This form may not be altered.

_____ ____/____/____
Child/Student first and last name Date of birth

I _____ verify that the above listed student had
Parent/Guardian/Self (if age 18 or older)

varicella (chickenpox) disease in _____/_____.
Month Year

_____ _____/_____/____
Signature of parent or guardian of child/student, or student if age 18 or older Date

Submit this form to the child care program, school or college.

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