BLUEFIELD COLLEGE

Student Health Information

Personal Information *(required)*

Student ID #: _____ Date of Birth: ___/ _____/ _____ Sex: ☐ M ☐ F

Name: *First:* _____ *MI* _____ *Last* _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Information *(required)*

Name: _____ Relationship: _____

Work Phone: (_____) _____ Home Phone: (_____) _____

Cell Phone: (_____) _____

Personal Health Information *(required)*

Do you have any allergies? ☐ No ☐ Yes Please specify your allergies below (Medication, Food, other).

_____

_____

_____

List all medication taken on a regular basis, including over-the-counter medication:

Medication Name	Dosage	When Taken (daily, weekly, monthly)

List any hospital stays you have had, including date and reason for stay: _____

_____

_____

Medical Health Information

Personal Health Information *(optional, but recommended)*

Do you have or have had any of the following:

CONDITION	Yes	No	Date	CONDITION	Yes	No	Date
Asthma				Kidney disease/disorder			
Diabetes				Mental illness/disorder			
Ear Disease/hearing problems				Mononucleosis			
Epilepsy/seizures				Muscular disease/disorder			
Eye disease/disorder				Physical limitations			
Hay fever/seasonal allergies				Stomach/intestinal trouble			
Heart disease/disorder				Vertigo/dizziness			

List any illness/ condition, not listed above, for which you are being treated: _____

_____

_____

Immunizations/Screenings *(required)*

*The immunizations/screenings listed below are **required** by Virginia law.*

Required immunizations/screenings:

- DPT (Diphtheria/Pertussis/Tetanus) Series
- IPV/OPV (Polio) Series
- Tetanus *(Must have received within 10 years of registration)*
- MMR (Measles/Mumps/Rubella) Series

Please provide/ attach a copy of your immunization record with signature of health care provider.

Medical Health Information

Immunizations/Screenings *(optional, but recommended)*

RECOMMENDED for All Applicants

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 undergraduate unless a waiver is signed.*

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.*

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

Please find required waivers on last page of the form.

Frequently asked questions can be found at
https://www.cdc.gov/vaccines/vac-gen/default.htm

Consent for Medical Treatment and Release of Information (*required)*

As a student of Bluefield College, I realize that it is possible for a medical emergency to occur. Therefore, I hereby authorize Bluefield College Student Development permission to release the medical information listed below to the appropriate officials (i.e. Residence Life staff and Campus Safety). In the event of an emergency, I authorize treatment for myself as deemed necessary by a licensed health care professional. I understand that my records will be kept confidential at all times by these officials. I also authorize BC to release information concerning my medical condition to the following individuals:

☐ Mother ☐ Father ☐ Guardian ☐ Professors ☐ Other: _____

Student Signature: _____ Date: _____

Parent/legal guardian: _____ Date: _____

Required if Student is a minor

BLUEFIELD COLLEGE

Medical Health Information

Insurance Information *(required)*

Please complete the information below and attach a copy of your health insurance card (front and back)

Insurance Company : Name _____ Policy Number _____

Address _____ City _____ ST _____ Zip _____

Group Number _____ Telephone Number _____

Policyholder: Name _____ Employer _____

Last four digits of **Social Security** Number _____ Date of Birth: ___/_____/_____

Student Affirmation *(required)*

My signature below indicates that the information provided on this form is accurate and complete, and that all immunizations and required screening/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 for minor student Date

Please return forms directly to Student Development at:

ATTN: Student Development
3000 College Ave.
Bluefield, VA 24605

Student Development Contact Info:

Phone: 276-326-4207
Email: wclark@bluefield.edu

BLUEFIELD COLLEGE

Medical Health Information

IMMUNIZATION WAIVER FORMS

WAIVER OF IMMUNIZATION AGAINST HEPATITIS B

The Code of Virginia (Chapter 340 23-7.5) requires that "each full-time student shall be vaccinated against hepatitis B unless the student or, if the student is a minor, the student's parent or legal guardian signs a written waiver stating that he has received and reviewed detailed information on the risks associated with hepatitis B and the availability and effectiveness of any vaccine and has chosen not be or not to have the student vaccinated."

I have read the Hepatitis B Frequently Asked Questions at https://www.cdc.gov/hepatitis/hbv/bfaq.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 _____ Date of Birth ___/___/_____

Student Signature _____ Date: _____

Parent/ Guardian Signature _____ Date: _____

Required if student is a minor

WAIVER OF IMMUNIZATION AGAINST MENINGOCOCCAL (MENINGITITS)

The Code of Virginia (Chapter 340 23-7.5) requires that "each full-time student shall be vaccinated against Meningococcal (Meningitis) unless the student or, if the student is a minor, the student's parent or legal guardian signs a written waiver stating that he has received and reviewed detailed information on the risks associated with Meningococcal (Meningitis) and the availability and effectiveness of any vaccine and has chosen not be or not to have the student vaccinated."

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

I choose not to be vaccinated Meningococcal.

Print Name _____ Date of Birth ___/___/_____

Student Signature _____ Date: _____

Parent/ Guardian Signature _____ Date: _____

Required if student is a minor