Castleton University

HEALTH FORM

All students taking more than 6 credits on any Castleton University campus (i.e., Castleton, Killington, or Bennington) are required by the State of Vermont Department of Health to submit the Castleton University Wellness Center health form.

FOLLOW THESE FOUR EASY STEPS:

1. Print this form.

2. You and your physician complete the form. Your required physical must have been completed within the 12 months prior to the start of your first semester at Castleton.

3. Fax your completed health form to: 802-468-1104, or mail to:
   Castleton University
   Wellness Center
   49 University Drive
   Castleton, VT 05735-9987

4. Keep a copy of your completed form.

If your health form is not received one month prior to the start of the semester, a hold may be placed on your account.

If you have any questions or concerns, please contact Jeanean Dunlap, Senior Staff Assistant in the Wellness Center at (802) 468-1346.

ATHLETES, PLEASE NOTE:
Your athletic forms will NOT fulfill the Wellness Center requirements. You must also complete the University Health Form.

Castleton University
Wellness Center
counseling, nursing, wellness education

STUDENT HEALTH FORM

IMPORTANT DEADLINES: DUE AUGUST 1 FOR AUGUST ENTRY (FALL SEMESTER)
Due January 1 for January Entry(spring semester)

Return this Health form to: Castleton University Wellness Center
Fax: 802-468-1104
49 University Dr.
Castleton, VT 05735
Phone: 802-468-1346

Name_____
First Middle Last

Preferred Name_____**Date of Birth** _____/_____/_____
month / day / year

Gender _____**Preferred Pronoun**_____

Student ID # _____

Admit term_____ **Cell Phone #**_____
or Preferred Phone to contact you.

PERSONAL HEALTH HISTORY – TO BE COMPLETED BY STUDENT

Medicines: List all prescription and over-the-counter medicines and supplements (herbal and nutritional) you are currently taking:

Do you have allergies? ☐ No ☐ Yes If yes, identify specific allergen:
☐ Medicines ☐ Pollen ☐ Food ☐ Stinging Insects

Have you ever had any of the following (comment on all "Yes" answers below):

	Yes	No		Yes	No		Yes	No
Asthma			Concussion / Head Injury			Irregular Menstruation		
Diabetes			Migraines			Abnormal Pap test		
Epilepsy / Seizure Disorder			Frequent or Severe Headaches			Fibrocystic Breasts		
Eye Problems			Hearing Loss			Tumor or cancer		
Ear, Nose, Throat Problems			Fainting spells			Missing Organ		
Congenital or Other Heart Problems			Musculoskeletal Injury			Hernia		
Thyroid Disorder			Other orthopedic problems			Eating Disorder		
Kidney or bladder infection			Paralysis			ADD / ADHD		
Stomach or Intestinal Problems			Anemia or Other Blood Disorders			Worry or anxiety		
Sinusitis			Mononucleosis			Clinical depression		
Skin disease			Sickle Cell Disease			Treatment for Alcohol or Drug Use		
TB/Positive TB test			CHICKEN POX - Must complete pg5			Surgery		

Comment on all *YES* answers:

FAMILY HISTORY

Have parents, siblings, or grandparents had any of the following? If adopted and history unknown, check 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:_____

Name: _____ DOB: _____

ENTRANCE HISTORY AND PHYSICAL

TO BE COMPLETED BY HEALTH CARE PROVIDER AND SIGNED AT THE BOTTOM. (NOT TO BE COMPLETED BY A RELATIVE).

B/P:	Pulse:	Ht:	Wt:	(Corrected) Vision: L 20/ R 20/

	Normal	Abnormal		Normal	Abnormal
General Appearance			Cardiac		
Head, face, scalp, skull			Neurologic		
HEENT			Breasts		
Neck / Thyroid			Abdomen (inc hernia)		
Skin			Genitals (inc testicular exam)		
Lungs			Musculoskeletal		

Comment on any *ABNORMAL* findings:

IS THIS PERSON CURRENTLY UNDER TREATMENT FOR ANY MEDICAL, EMOTIONAL OR PSYCHIATRIC CONDITIONS?

☐ **NO** ☐ **YES – SPECIFY:**

TUBERCULOSIS SCREENING RISK FACTORS

(must be completed by ALL Students)

- History of a positive TB skin test? ☐ Yes ☐ No
- Recent close contact with anyone who was sick with TB? ☐ Yes ☐ No
- History of cancer, leukemia, diabetes, kidney disease, HIV/AIDS, low body weight, chronic malabsorption syndrome, organ transplant, IV drug use or use of immunosuppressive meds such as prednisone? ☐ Yes ☐ No
- Resident, employee or volunteer in a high-risk congregate setting (correctional facility, nursing home, homeless shelter, hospital)? ☐ Yes ☐ No
- Foreign-born in one of the countries listed below and arrived in the US within the past 5 years? (If yes, circle the country) ☐ Yes ☐ No

If YES answer to any of the above: TB Skin Test (TST) OR Interferon-Gamma Release Assay (IGRA) is required.
A history of BCG vaccination does not preclude testing.
Unlike TST, IGRA is not influenced by prior BCG vaccination

TST: Date Placed:_____ Date Read:_____ Result:_____mm of induration

OR

IGRA: Date Obtained _____ Result: ☐ Negative ☐ Positive ☐ Indeterminate ☐ Borderline (T-Spot only)

If positive TST or IGRA chest X-ray required: Date of X-ray:_____ Result: ☐ Normal ☐ Abnormal

Countries with High Rates of TB

("High Incidence" areas are defined as areas with reported or estimated incidence of ≥20 cases per 100,000 population)

Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia & Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China, Colombia, Comoros, Congo, Congo DR, Cook Islands, Cote d'Ivoire, Croatia, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Korea-DPR, Korea-Rep, Kuwait, Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Macedonia-TFYR, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Micronesia, Moldova-Rep, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Romania, Russian Federation, Rwanda, St. Vincent & the Grenadines, Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Syrian Arab Republic, Swaziland, Tajikistan, Tanzania-UR, Thailand, Timor-Leste, Togo, Tonga, Trinidad & Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, Uruguay, Uzbekistan, Vanuatu, Venezuela, Vietnam, Yemen, Zambia, Zimbabwe

Name of Health Care Provider (Print)_____ **Date Exam completed**_____

Address_____ **City/State/Zip**_____

Phone_____ **Fax**_____

Signature_____ **Date Signed**_____

Name _____ DOB _____

IMMUNIZATION RECORD

THIS FORM MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER.

REQUIRED VACCINES

Vaccines	Dates Given	Vermont State Requirements
MMR	**#1** ___/___/___ **#2** ___/___/___ **OR** Positive Titer Date: ___/___/____ Must include lab results.	2 doses **or** positive titers Minimum of 4 weeks between doses 1st dose given after 1st birthday
Tdap	Tdap ___/___/___	1 Tdap (if immunization date is 10 yrs or older will need Tetnus booster)
Meningococcal*	___/___/___ ☐ Menveo ☐ Menactra	* Students living on campus-1 or 2 doses MenACWY; **if only 1 dose BEFORE age 16, a second dose is needed.***
Varicella (Chicken Pox)	**#1** ___/___/___ **#2** __/__/__ **OR** Positive Titer Date: ___/___/___ Must include lab results. **History of Disease: ☐ No ☐ Yes Must complete pg5**	2 doses Varicella Vaccine **or** Positive Titer **or History of Disease** Minimum of 4 weeks between doses if age 13 or older
Hepatitis B	**#1** ___/___/___ **#2** ___/___/___ **#3**___/___/___ **OR** Positive Titer Date: ___/___/___ Must include lab results.	3 doses **or** positive titer Minimum 1 month between doses 1 and 2 Minimum 2 months between doses 2 and 3 Minimum 4 months between doses 1 and 3

RECOMMENDED / OPTIONAL VACCINES

Vaccines	Dates Given	Recommendations
Hepatitis A	#1 ___/___/___ #2 ___/___/___	Recommended if planning to travel Interval: 6-12 months between doses 1 and 2
Hib	#1 ___/___/___	Primary series
HPV	#1___/___/__ #2___/___/___#3___/___/__	Health care maintenance
Influenza	Most recent: ___/___/___	
Pneumococcal	#1 ___/___/___ ☐ Polysaccharide (PPV) ☐ Conjugate (PCV)	Chronic health problems
Polio	Primary series: ☐ Oral ☐ Injectable Most recent booster: ___/___/___	Primary series
Rabies	#1___/___/__ #2___/___/___ #3 ___/___/___	Travel / occupational
Typhoid	☐ Oral ☐ Injectable	Travel
Yellow Fever	#1 ___/___/___	Travel

SIGNATURE OF HEALTH CARE PROVIDER: _____

Print **Signature** **Date**

Name: _____ DOB: _____

EMERGENCY NOTIFICATION

Please provide 2 emergency contacts. Please don't list parents separately if they live in the same home.
(1) Your parent/guardian (2) Someone other than your parent/guardian to call if a parent/guardian is not available.

(1) Name _____	(2) Name _____
Relationship _____	Relationship _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Country _____	Country _____
Telephone _____ Home	Telephone _____ Home
_____ Work	_____ Work
_____ Cell	_____ Cell

Castleton University Wellness Center Commitment to Confidentiality

All medical and counseling records at Castleton are confidential and are completely separate from all other University records. Students have the right to revoke or restrict authorization to share health care information, and Castleton will not release any information about you without your written permission, except under the following conditions:

- *As authorized or required by law (i.e., when we are presented with a valid court order requiring us to release records);*
- *As necessary to protect you or others from a serious threat to health or safety;*
- *As necessary to notify parents and deans when you have a serious mental or physical health problem and are unable to assume responsibility for notifying others.*

In addition, the Wellness Center staff may confer with one another as needed to provide integrated care for you. Castleton also works with local clinics to ensure a full range of medical and mental health options for students; when students receive treatment at multiple offices, we exchange only such information as is needed to maintain continuity of care with students' written permission. Students may make requests to the Wellness Center to revoke or restrict authorization to share such information.
While this written summary of confidentiality and its limits should prove helpful in informing you, it is important that we discuss any questions or concerns that you may have. We are happy to discuss these issues with you.

My signature below indicates that:

- I consent to receive triage services provided by the Wellness Center staff.
- The information on this form is correct and complete to the best of my knowledge.
- I have read the above Commitment to Confidentiality.
- I understand the University Wellness Center is required by state law to report positive results of certain laboratory tests and certain immunizations to the Vermont Department of Health.
- I authorize the Wellness Center to contact my health care provider about any information missing from my medical examination or immunization record.
- If I require specialist services, lab testing, x-rays, prescriptions, or other referrals beyond the primary care services available at Castleton University Wellness Center, I shall assume the financial responsibility or negotiate satisfactory arrangements with the caregiver.

Signature of student_____ Date_____

*Signature of parent/guardian_____ Date_____
*Required if student is not yet 18 years old.

PLEASE RETURN THIS FORM TO THE WELLNESS CENTER (SEE PAGE ONE) NOT ADMISSIONS.

Documentation of Varicella (Chickenpox) Disease

VERMONT
DEPARTMENT OF HEALTH

Vermont's School Immunization Regulations apply to students in attendance at any public or independent kindergarten, any elementary or secondary school and certain post-secondary schools. Before school entry, students must have the required immunizations, including 2 doses of varicella (chickenpox) vaccine. However, students who have had chickenpox disease can still enroll provided this form be completed, signed and provided to the school. Please note that this form does not need to be signed by a physician or other health care provider. **RETURN THIS FORM TO THE STUDENT'S SCHOOL.**

This document is being submitted on behalf of the following student:

Name:

_____ _____
Last First

Date of Birth :

____/____/_____

I _____ **verify that the above listed student**
Parent/Guardian/Self (18 and over)

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

_____ ____/____/_____
Signature of parent or guardian of student or student 18 and over Date

RETURN THIS FORM TO THE STUDENT'S SCHOOL

The Vermont Department of Health
Immunization Program
108 Cherry Street
Burlington, Vermont 05401

802-863-7638 or
1-800-464-4343 ext. 7638
healthvermont.gov

Academic Year 2019-20
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