

WELCOME TO STUDENT HEALTH AND WELLNESS

Dear New University of Virginia Student:

The Department of Student Health and Wellness wishes to congratulate you on your acceptance to the University of Virginia! Our faculty and staff are here to help you maintain a foundation of quality health and to help restore you to a state of wellbeing in the event of illness, injury, or mental health concern.

Building immunity to common communicable diseases is a critical first step in protecting your health and that of your fellow students. Completion of the [Pre-entrance Health Form](#) on the following pages allows you to demonstrate that you have met the basic immunization requirements known to promote a healthy campus community.

Another important step in preparing for school is to plan for your unique health care needs. The Department of Student Health and Wellness offers a wide variety of health services.



Schedule a Welcome Visit:

To schedule a welcome visit, please call 434-982-3915 or schedule online using the HealthyHoos portal. Primary Care providers are listed on our website: <http://www.studenthealth.virginia.edu/meet-our-team-pc>



Care Managers:

Care Managers can offer advice to new students who are seeking to make connections with a specialist in our area, including mental health providers. Care Managers can be reached in Counseling and Psychological Services (CAPS) by calling **434-243-5150** or in Medical Services by calling **434-982-3915**.



Allergy Clinic

Our Allergy Clinic can continue allergy immunotherapy injections ordered by your outside allergist while you are at school. For more information, please visit our website: <https://www.studenthealth.virginia.edu/allergy-clinic>



Student Disability Access Center (SDAC):

SDAC provides a wide range of individualized services and accommodations for students with disabilities in order to provide an inclusive and accessible educational experience. Students are registered with SDAC for a variety of disabilities, temporary conditions (such as broken bones), and various sensory-related disorders. Common accommodations include exam accommodations, note taking assistance, advocacy with attendance and assignment due dates, and housing-related accommodations. Students can apply online to begin the intake and eligibility process: <http://www.studenthealth.virginia.edu/sdac>

Due Dates for Submitting Your Form:

Fall Entry: 8-1-19 Spring Entry: 1-31-20

You and your health care provider must complete and sign this form. The form must be submitted by uploading to our secure website:

<https://www.healthyhoos.virginia.edu>
(requires NetBadge account).

Click on "Upload" and follow the instructions.

Questions? Contact Medical Records at 434-924-1525.

Sincerely,
Christopher Holstege, M.D.
Executive Director

Department of Student Health and Wellness
University of Virginia
P. O. Box 800760
400 Brandon Avenue
Charlottesville, VA 22908-0760
Website: <http://www.virginia.edu/studenthealth>

Entire Form due August 1st, 2019 for Fall or January 31st, 2020 for Spring to avoid \$100 processing fee.

Pre-Entrance Health Form: PART I

[TO BE COMPLETED BY INCOMING STUDENT OR PARENT/LEGAL GUARDIAN]

Student Name: _____
Last First Middle

Date of Birth: ____/____/____ University ID# _____ State or Country of Birth: _____

Address: _____
Street City State Zip

Name or parent or Legal Guardian 1: _____ Phone ____-____-____ Work or Cell ____-____-____

Name of Parent or Legal Guardian 2: _____ Phone ____-____-____ Work or Cell ____-____-____

Emergency Contact: _____ Phone ____-____-____ Work or Cell ____-____-____

Long Term Signature Agreement

To be completed by the student or parent/legal guardian for minor. Signing this Long-Term Signature Agreement assures that relevant information can be sent to your insurance company if insurance claims are filed on your behalf.

I hereby assign the benefits of my insurance policy to the University of Virginia Student Health Department and University of Virginia Health System, as appropriate. I understand that I am responsible for all charges that are not paid by that policy.

Student/Parent Signature: _____ Date: ____/____/____

Consent for the Treatment of Minors (for students 17 years and younger)

To be completed by parents or legal guardians of students who will be under the age of 18 when arriving on Grounds.

The University of Virginia Department of Student Health and Wellness has my permission to treat my minor child in the event of a medical emergency. The University of Virginia Department of Student Health and Wellness also has my permission to treat my child for routine medical care, including check-ups, immunizations, and/or treatment for minor injuries and illnesses.

Student/Parent Signature: _____ Date: ____/____/____

Alert: Insurance/Hard Waiver

The University of Virginia requires all students who pay the comprehensive fee with their tuition to have health insurance that meets specific coverage requirements (i.e., comparable coverage). This is also known as the health insurance **hard waiver** program. Proof of insurance must be submitted online by the deadline in order to meet this requirement at the following address:
www.uvstudentinsurance.com

If proof of comparable coverage is not submitted (whether a student fails to submit any documentation or because a student's health plan is determined not to provide adequate comparable coverage), the student will be responsible for the full cost for single coverage under the University-endorsed Aetna Student Health Insurance plan.

For more information: <https://www.studenthealth.virginia.edu/hard-waiver>.

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Pre-Entrance Health Form: PART II

[TO BE COMPLETED BY INCOMING STUDENT OR PARENT/LEGAL GUARDIAN]

Tuberculosis (TB) Screening Questionnaire

Have you ever had close contact with persons known or suspected to have active TB disease? YES NO

Have you had a previous positive TB test? YES NO

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? YES NO

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? YES NO

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? YES NO

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country below.) YES NO

Have you had frequent or prolonged visits to one or more of the countries or territories listed below with a high prevalence of TB disease? (If yes, CHECK the country below.) YES NO

Afghanistan	China, Hong Kong SAR	India	Myanmar	Solomon Islands
Albania	China, Macao SAR	Indonesia	Namibia	Somalia
Algeria	Colombia	Iraq	Nauru	South Africa
Angola	Comoros	Kazakhstan	Nepal	South Korea (Republic of Korea)
Anguilla	Congo	Kenya	Nicaragua	South Sudan
Argentina	Côte d'Ivoire	Kiribati	Niger	Sri Lanka
Armenia	Democratic Republic of the	Kuwait	Nigeria	Sudan
Azerbaijan	Congo	Kyrgyzstan	Niue	Suriname
Bahamas	Djibouti	Lao People's Democratic Republic	Northern Mariana Islands	Tanzania (United Republic)
Bangladesh	Dominican Republic	Latvia	North Korea (Democratic	Tajikistan
Belarus	Ecuador	Lesotho	People's Republic)	Thailand
Belize	El Salvador	Liberia	Pakistan	Timor-Leste
Benin	Equatorial Guinea	Libya	Palau	Tokelau
Bhutan	Eritrea	Lithuania	Panama	Togo
Bolivia	Ethiopia	Madagascar	Papua New Guinea	Tunisia
Bosnia and Herzegovina	Fiji	Malawi	Paraguay	Turkmenistan
Botswana	Gabon	Malaysia	Peru	Tuvalu
Brazil	Gambia	Maldives	Philippines	Uganda
Brunei Darussalam	Georgia	Mali	Portugal	Ukraine
Bulgaria	Ghana	Marshall Islands	Qatar	Uruguay
Burkina Faso	Greenland	Mauritania	Romania	Uzbekistan
Burundi	Guam	Mexico	Rwanda	Vanuatu
Cabo Verde	Guatemala	Micronesia (Federated States of)	Sao Tome and Principe	Venezuela (Bolivarian
Cambodia	Guinea	Moldova (Republic of)	Senegal	Republic of)
Cameroon	Guinea-Bissau	Mongolia	Serbia	Viet Nam
Central African Republic	Guyana	Montenegro	Sierra Leone	Yemen
Chad	Haiti	Morocco	Singapore	Zambia
China	Honduras	Mozambique		Zimbabwe

Source: Virginia Department of Health. Data obtained from 2018 World Health Global Tuberculosis Report and reflects 2017 data. Countries with TB incidence rates of $\geq 20/100,000$ population.

I affirm that all of the above information is accurate.

Student Name: _____ Signature: _____ Date: _____

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Pre-Entrance Health Form: PART III

[TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER.]

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. For more information about immunization requirements or exemption forms:

<http://www.studenthealth.virginia.edu/pre-entrance-health-form>

Required Vaccines	Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given			
Tdap (one dose required on or after 10 th birthday)	1			
Tetanus Booster (if Tdap > 10 years ago)	1			
Polio (IPV, OPV)	1	2	3	4
Measles, Mumps, Rubella (MMR) Vaccine	1	2		
Measles (Rubeola)	1	2	Or date of Serologic Confirmation of Measles Immunity (must attach copy of lab result):	
Rubella	1		Or date of Serologic Confirmation of Rubella Immunity (must attach copy of lab result):	
Mumps	1	2	Or date of Serologic Confirmation of Mumps Immunity (must attach copy of lab result):	
Meningococcal Vaccine (A, C, Y, W-135) (initial or booster dose must be on or after 16 th birthday) Required only for students < 22 years of age.	1			
Hepatitis B Vaccine <input type="checkbox"/> 2-dose vaccine used to complete series.	1	2	3	Or date of Serologic Confirmation of Hepatitis B Immunity (must attach copy of lab result):
Recommended Vaccines	Record Complete Dates (mm/dd/yyyy) of Vaccine Doses Given			
Hepatitis A	1	2		
Human Papillomavirus Vaccine (HPV)	1	2	3	
Serogroup B Meningococcal Vaccine <input type="checkbox"/> MenB-4C <input type="checkbox"/> MenB-FHpb	1	2	3	
Varicella	1	2	Or date of Varicella Disease or Serologic Confirmation of Varicella Immunity (must attach copy of lab result):	
Other	1	2	3	4
Other	1	2	3	4
Required Tuberculosis Screening (all students): All steps must be after 3/1/19 (Fall) or 7/1/19 (Spring)				
Tuberculosis Screening Questionnaire Result (see page 2)	<input type="checkbox"/> Positive (any questionnaire response of "yes")	<input type="checkbox"/> Negative (all questionnaire responses "no")		
Tuberculosis Testing Result. Required only if TB Screening Questionnaire Positive. IGRA required for students from any country listed on page 2. IGRA preferred for all other students.	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Test method: <input type="checkbox"/> IGRA <input type="checkbox"/> PPD	Date of Test:	Must attach copy of result for IGRA.
Chest X-ray result. Required only if Tuberculosis Testing Positive.	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date of test:	Must attach copy of report.
All students with a positive IGRA or TST with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication.				

HEALTH CARE PROVIDER:

Signature of Medical Provider/Health Department Official: _____

Medical Provider Printed Name: _____ Date: _____

Address: _____ Phone: ____ - ____ - ____