Student Health Assessment

Office of Student Affairs | P.O. Box 2092 | 101 College Hill Dr. | Philippi, WV 26416 | (304) 457-6213

Alderson Broaddus University requires all new students (transfers and freshman) to complete the Student Health Assessment Form prior to attending ABU. This form must be completed in its entirety and received by The Office of Student Affairs by August 1 for students starting in the Fall semester and January 1 for students starting in the Spring semester. Be sure to include your name on the top of all pages in case the forms get separated.

Pages 2-4 of the Student Health Assessment are to be completed by the student. Pages 5-6 are to be completed by a physician. Please be sure that the physician completes every required field. Should you or the physician have any questions about the form or requirements, please do not hesitate to contact The Office of Student Affairs at the number listed above.

Student Athletes:

The Athletic Training Department requires completion of this Student Health Assessment as well as a few additional forms. If you are a Student Athlete, please complete the Student Athlete. Once completed, ALL pages will need to be turned into The Office of Student Affairs. A copy of the forms will be sent to the Athletic Training Department. Do not turn in any portion of the Student Health Assessment to The Athletic Training Department.

Submission Information:

Upon completion of the forms, please fax, email, or mail all forms to The Office of Student Affairs.

Address:

Alderson Broaddus University
Office of Student Affairs
Student Health Assessment
101 College Hill Drive
Box 2092
Philippi, WV 26416

Email:

Studentaffairs@ab.edu (Please include Student Health Assessment in the subject line.)

Fax Number:

(304)457-6213

The Office of Student Affairs will send a confirmation email to your Battler email when the completed Student Health Assessment is received. If the form is received, but not complete, you will receive an email indicating what information is missing. If you receive an email that your Student Health Assessment is incomplete, you will need to complete it by the deadline given in the email. If the Student Health Assessment Form is not completed by the deadline, student will not be allowed to attend Alderson Broaddus University and/or live in the Residence Halls.

***We recommend that you make a copy of this form for your records.**

New Student
Student Health Assessment

Office of Student Affairs | P.O. Box 2092 | 101 College Hill Dr. | Philippi, WV 26416 | (304) 457-6213

Student Information Form

Name of Student_____

Last Name:	First Name:		MI:
Date of Birth: (MM/DD/YY):	Home Address:		
City:	State:	Zip Code:	Country:
Home Phone Number:	Cell Phone Number:		Sport (If an ABU Athlete):
Please list all Medications (Include dosage and frequency):			
Please list all Allergies (medical, food, airborne, etc.):			

Emergency Contact Information (Please Fill Both)

Name:	Relationship:
Address:	
Primary Phone Number:	E-Mail Address:

Name:	Relationship:
Address:	
Primary Phone Number:	E-Mail Address:

Insurance Information

Name of Policy Holder	Insurance Company	
Policy Number:	Policy Holder's Home Address:	
Policy Holder's Employer	Employer's Address	Employer's Phone Number

Please return form to: Alderson Broaddus University, Office of Student Affairs, Box 2092, 101 College Hill, Philippi, WV 26416
PLEASE MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS

Alderson Broaddus University Insurance Questionnaire

Please note: All student athletes are **REQUIRED** to have a health insurance policy that includes athletic participation or an athletic rider.

Name of Student_____

Policy Holder's Information

Name:_____ Date of Birth:_____

Home Phone:_____ Employer:_____ Employer Phone:_____

Insurance Company:_____ Address:_____

_____

Policy Number:_____

Do you have Group Medical Insurance coverage through your Employment?

☐ Yes, Group Number:_____ ☐ No

Please confirm by initialing on the line that you have read and understand the information below:

1. I confirm I am an athlete and my insurance will cover any athletic related injury while participating in intercollegiate sports at Alderson Broaddus University in the state of West Virginia _____
2. I understand I am responsible to provide updated insurance information to Alderson Broaddus University if there are any changes within the policy _____
3. I understand that if I drop my insurance I am responsible for any charges related to medical treatment, even if it results from an injury that occurred at a supervised practice or contest at Alderson Broaddus University_____

A. Will you be participating in Intercollegiate Sports? ☐ Yes ☐ No

If yes, what Sport(s)?_____

B. I give my permission to the Office of Student Affairs (OSA) to provide a copy of this Health Form to the Athletic Training Staff. ☐ Yes ☐ No

C. I give my permission to the Office of Student Affairs (OSA) to provide a copy of my Health Form records to Broaddus Hospital to assist with my registration at the hospital if needed.

☐ Yes ☐ No

Student Signature _____ Date_____

PARENT/GUARDIAN SIGNATURE REQUIRED IF STUDENT IS UNDER 18 YEARS OF AGE

If under the age 18, please have your parent/guardian sign here: Authorized permission is required for emergency treatment, outpatient treatment, or laboratory testing at any hospital or medical facility if your child is under the age of 18.

Parent/Guardian Signature_____ Date_____

****TO COMPLETE THIS FORM YOU MUST INCLUDE A PHOTOCOPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD****

Alderson Broaddus University Student Health Assessment
(Completed by Student)

Name of Student:			Date of Birth:
	Yes	No	Please explain all YES answers:
1. Have you had an illness or injury since your last check up or sport physical?			
2. Have you ever been hospitalized overnight?			
3. Have you ever had surgery?			
4. Have you ever been tested for or diagnosed with ADD/ADHD?			
5. Have you ever taken any supplement/vitamins to help gain or lose weight?			
6. Have you ever taken any supplements/vitamins to help athletic performance?			
7. Have you ever had a rash or hives develop during or after exercise?			
8. Have you ever passed out during or after exercise?			
9. Have you ever been dizzy during or after exercise?			
10. Have you ever experienced severe cramping during exercise?			
11. Have you or a family member been diagnosed with sickle cell disease or trait?			
12. Have you ever been dizzy, passed out, or become ill from exercising in the heat?			
13. Have you ever had chest pain during or after exercise?			
14. Do you tire more quickly during exercise than your friends?			
15. Have you ever had a racing of your heart or felt your heart skip beats?			
16. Have you ever had high blood pressure or high cholesterol?			
17. Have you ever been told that you have a heart murmur?			
18. Has anyone in your family had a heart attack or died suddenly before the age of 50?			
19. Have you had a severe viral infection (i.e. myocarditis, mono, etc)?			
20. Has a physician ever denied or restricted your participation in sports for any heart related problem?			
21. Do you have specific knowledge of certain cardiac conditions in family (i.e. cardiomyopathy, long qt syndrome, marfan syndrome, arrhthymias)?			
22. Have you ever been knocked unconscious or suffered a concussion?			
23. Have you ever had a seizure?			
24. Do you have frequent or severe headaches?			
25. Have you ever had numbness, tingling in your arms, hands, legs, or feet?			
26. Have you ever had a stinger, burner, or pinched nerve?			
27. Do you cough, wheeze, or have trouble breathing during or after exercise?			
28. Do you have asthma?			
29. Do you have seasonal allergies requiring medical treatment?			
30. Do you use any special protective or corrective equipment that aren't usually used for your sport? (i.e. braces, orthotics, hearing aids, etc)			
31. Have you had any problems with your eyes or vision?			
32. Do you wear glasses, contacts, or protective eyewear?			
33. Have you ever had a sprain, strain, or swelling after an injury?			
34. Have you ever broken, fractured, or dislocated any bones or joints?			
35. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?			
If YES to Questions 33 - 35, please circle and explain -----> Head — Hip/Thigh Neck/Back — Knee Chest/Shoulder — Shins Elbow/Forearm — Ankle/Foot Wrist/Hand/Fingers			
36. Are you undergoing treatment or counseling for emotional problems?			
37. Have you ever been advised by a doctor NOT to participate in sports?			

Additional Notes

I hereby state that, to my best knowledge, my answers to the questions are complete and correct *Parent Signature only required if under 18 years old*

Signature of Student *Signature of Parent

Please return form to: Alderson Broaddus University, Office of Student Affairs, 101 College Hill, Box 2092, Philippi, WV 26416

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IMMUNIZATION RECORD AND PHYSICAL EXAMINATION
Completed by Physician, Page 1 of 2

Required Vaccinations

Name of Student _____

Current 2 Step PPD Within Past 6 Months	Date of Negative chest X-ray: (Within Past 6 Months) ____ mm | ____ dd | ____ yy **OR**	Date of Shot: ____ mm | ____ yy	Reaction #1:

M.M.R. (Measles, Mumps, Rubella):	Dose #1 ____ mm | ____ yy	Dose #2 ____ mm | ____ yy	Titer: **OR** ____ Yes ____ No ____ Date

Varicella	Date #1 ____ mm | ____ yy	Date #2 ____ mm | ____ yy **OR**	Varicella Titer ____ mm | ____ yy Reactive:____ Non-Reactive ____

Hepatitis B:	Date #1 ____ mm | ____ yy	Date #2 ____ mm | ____ yy	Date #3 ____ mm | ____ yy **OR**	Anti- HBs Titer: ____ Yes ____ No ____ Date

Diphtheria-Pertussis-Tetanus (DPT) or Date of most recent Tetanus Booster Booster REQUIRED if longer than 10 years since initial vaccination.	____ mm | ____ yy
Meningococcal: This is REQUIRED by the University for ALL new students living in residence halls AND is recommended for all students who wish to reduce the risk of meningococcal disease.	____ mm | ____ yy

Recommended Vaccination

Quadrivalent Human Papillomavirus Vaccine (HPV)	Date #1 ____ mm | ____ yy	Date #2 ____ mm | ____ yy	Date #3 ____ mm | ____ yy

For students planning to live on campus: Are you aware of any conditions that would prevent this patient from living in a college residence hall? ☐ Yes ☐ No

If yes, please explain. Additional documentation may be required for housing exemption:

_____

_____

_____

Physician Name	Date
Address	Phone
Signature of Physician	

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IMMUNIZATION RECORD AND PHYSICAL EXAMINATION
Completed by Physician, Page 2 of 2

Name of Student _____

Height	Vision:	R 20/		Peak Flow:
Weight		L 20/		
Pulse	Corrected:	YES	NO	
Right BP		Contacts	Glasses	
Left BP	Pupils:	Equal	Unequal	

	Normal	Abnormal Findings
Medical		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Marfan Screen		
Lungs		
Abdomen		
Genitalia (Males Only)		
Skin		

	Normal	Abnormal Findings
Musculoskeletal		
Neck		
Back		
Shoulder		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

CLEARANCE

TO THE MEDICAL EXAMINER: Following your examination of the person indicated above, please read each statement below, and **initial** inside the boxes beside each of the statements to indicate your agreement with the statement.

☐ I have performed a medical history and physical examination on the above named student and verify that the student is free from medical conditions which would endanger the health and well-being of other students.

☐ The above named student is cleared for ALL Physical Education Classes, Intercollegiate Athletics , and Campus Activities

☐ **Not Cleared for Following Reasons:**

Physician Name	Date
Address	Phone
Signature of Physician	

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