DAVIDSON
Student Health Center
Box 7188
Davidson, N.C. 28035-7188
Phone: 704-894-2300
FAX: 704-894-2615

Medical History and Physical Examination Form

REQUIRED OF ALL NEW STUDENTS ENTERING DAVIDSON COLLEGE

Please complete this required form in its entirety and return to the Student Health Center by June 30th.

Return via mail: Student Health Center, Box 7188, Davidson, N.C. 28035-7188; fax to 704-894-2615;
Or email to studenthealth@davidson.edu.

Full Name _____ Preferred Name _____

Expected College Graduation Year _____ Cell Phone Number _____

Date of Birth (month/day/year)_____ E-mail Address _____

Sex assigned at birth: M ___F___ Gender identity: Man ___ Woman ___Transgender ___ Other_____

Home Address _____ Home Phone ( ) _____

_____

Parents' Names _____

Parents' Employer_____ Work Phone ( ) _____

_____ Work Phone ( ) _____

_____
HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY)* * AREA CODE/TELEPHONE

_____
NAME OF POLICY HOLDER INSURED'S DATE OF BIRTH EMPLOYER

IS THIS AN HMO/PPO/MANAGED CARE PLAN? □ YES □ NO

_____
POLICY OR CERTIFICATE # GROUP #

Does your insurance require primary care physician authorization for referral to specialists? □ YES □ NO

_____
PRIMARY CARE PHYSICIAN PHONE # FAX #

_____
NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY RELATIONSHIP

_____
ADDRESS AREA CODE/TELEPHONE

**** Please attach a copy of both the front and back of insurance card.**

MENINGITIS INFO

North Carolina law requires that educational institutions with residential housing provide information to incoming students and parents about meningococcal disease.

Meningococcal disease is a serious illness. It can occur as meningococcal meningitis, an inflammation of the membrane surrounding the brain and spinal cord, or as meningococcemia, the presence of bacteria in the blood. Meningococcal disease is dangerous because its initial symptoms often mimic those of influenza or other respiratory infections or migraine headaches. Because of this, it is often misdiagnosed initially. Early symptoms include high fever, headache, nausea, vomiting and extreme fatigue. Meningococcal infections progress quickly.

Approximately 10 percent of people affected by meningococcal disease die, in spite of treatment with antibiotics. Another 10 percent suffer from permanent brain damage, deafness, limb amputation, or kidney failure.

The bacteria that cause meningococcal disease can be spread from person to person by direct contact with someone who is infected or through droplets released into the air through coughing. It can be spread by kissing, sharing a cigarette or drinking glass, eating utensils or anything else that an infected person has touched with his or her mouth.

Anyone can get meningococcal disease but lifestyle factors common among college students seem to be linked to the disease: crowded living conditions such as residence halls, going to bars, smoking, and irregular sleep habits. Meningitis is not a common illness but freshmen living in residence halls are at slightly increased risk of getting the disease.

Vaccines are now available to help protect against the serotypes of meningococcal disease that are most commonly seen in the United States. Students should understand that meningococcal vaccination can greatly decrease the risk of infection but is not 100 percent protective against all meningococcal disease.

Meningococcal vaccine is recommended for freshmen living in residence halls or for other students who want to lower their risk of the disease. The CDC recommends that the first vaccine be given at age 11 or 12 with a booster dose at age 16. If the first dose is received at age 16 or later a booster dose is not needed. Meningococcal vaccine should be available from your primary care physician or your local Health Department.

You can obtain additional information about meningococcal disease and the vaccine by visiting the Meningitis Foundation of American, www.musa.org; the National Meningitis Association, www.nmaus.org; or the Centers for Disease Control and Prevention, http://www.cdc.gov/vaccines/vpd-vac/mening/default.htm.

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT--The immunization requirements must be met or, in accordance with N.C. law, you will be withdrawn from classes without credit.

Acceptable records of your immunizations may be obtained from any of the following: (Be certain that your name and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. Keep a copy for your records.)

- High School Records--These may contain some, but not all of your immunization information. Contact Student Health for help if needed.
- Personal Shot Records--Must be certified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department.
- Military Records or WHO (World Health Organization Documents).
- Previous College or University-Your immunization records do not transfer automatically. You must request a copy.

SECTION A: IMMUNIZATION REQUIREMENTS ACCORDING TO AGE

I. STUDENTS 17 YEARS OF AGE OR YOUNGER	II. STUDENTS AGE 18 YEARS OF AGE OR OLDER
Vaccine Required	**Vaccine Required**
3 **DTP *(Diphtheria-Tetanus-Pertussis)* or Td *(Tetanus-Diphtheria)*** doses. Individuals entering college for the first time on or after July 2008 must have had 3 doses of tetanus-diphtheria toxoid and a booster dose of tetanus-diphtheria-pertussis vaccine, if a tetanus-diphtheria toxoid or a tetanus-diphtheria-pertussis vaccine has not been administered within the past 10 years. **3** **POLIO** doses **2*** **MEASLES *(Rubeola)*** one dose on or after 12 months of age, the 2nd after 15 months of age. (**2 MMR** doses meet this requirement.) **1**** **RUBELLA** *(German Measles)* dose. **2**** **MUMPS** **3** **HEPATITIS B**	**3** **DPT *(Diphtheria-Tetanus-Pertussis)* or Td** *(Tetanus-Diphtheria)* doses. Individuals entering college for the first time on or after July 2008 must have had 3 doses of tetanus-diphtheria toxoid and a booster dose of tetanus-diphtheria-pertussis vaccine, if a tetanus-diphtheria toxoid or a tetanus-diphtheria-pertussis vaccine has not been administered within the past 10 years. **2*** **Measles *(Rubeola)*** one dose on or after 12 months of age, the 2nd after 15 months of age. (2MMR doses meet this requirement.) **1**** **RUBELLA** *(German measles)* dose **2**** **MUMPS** **3** **HEPATITIS B** (Required if born 7/1/94 or after)
	Measles and Mumps vaccines are not required if you were born prior to 1957.
	Rubella vaccine is not required if you are age 50 or older.
III. TUBERCULOSIS (TB) RISK ASSESSMENT	
All new students entering Davidson College are required to present a **Tuberculosis Screening Form** (page 5) that has been signed by their medical provider. This is conducted as a risk assessment. If a student is at low risk, a PPD is not required for entrance to college. If a student is determined to be at high risk for TB (see form), they are required to present documentation of a current TB test on page 4 and results of a current chest x-ray if the TB test is positive. **Students entering from a country where TB is endemic will also have a TB skin test or an IGRA performed by Student Health.**	

* Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age.

** Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken.

SECTION B: These vaccines are RECOMMENDED.

SECTION C: These vaccines are OPTIONAL.

IMMUNIZATION RECORD *(Please print in black ink)* To be completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.

Last Name (print above) First Name Middle Name	Date of birth (mo./ day /year)	Davidson ID #

SECTION A Required Immunizations	mo./ day/ year	mo./day / year	mo. / day / year	mo. / day / year
• DPT or Td (Diphtheria-Pertussis-Tetanus or Tetanus-Diphtheria)	#1	#2	#3	#4
• Td (Tetanus-Diphtheria)				
• Tdap (Tetanus-Diphtheria-acellular Pertussis)				
• Polio				
• MMR (After first birthday)				
• Measles (After first birthday)			* Disease Date	*** Titer Date & Result
• Mumps			** (Disease Date Not Accepted)	*** Titer Date & Result
• Rubella			** (Disease Date Not Accepted)	*** Titer Date & Result
• Tuberculin (PPD) Test Date Read (**if indicated by page 5-TB Screening Form**)				
mm induration	mm			
Chest x-ray, if PPD positive Date				
Results				
INH treatment completion, if applicable Date				
• Hepatitis B Series (Required if born 7/1/94 or after)	#1	#2	#3	*** Titer Date & Result

SECTION B Recommended Immunizations; Not Required	mo./day/year	mo./day/year	mo./day/year	
• Human Papillomavirus (HPV) Vaccine	#1	#2	#3	
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	*** Titer Date & Result
• Meningococcal (Booster dose recommended at age 16)				

SECTION C Optional Immunizations	mo./ day / year	mo./day /year	mo. / day / year
• Hepatitis A series	#1	#2	
• Typhoid (specify type)			
• Yellow Fever			
• Serogroup B Meningococcal			
Other:			

Signature or Clinic Stamp **REQUIRED:**

Signature of Physician / Physician Assistant / Nurse Practitioner

Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Telephone / Fax Number

Office Address City State Zip Code

* Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age.
** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from physician, is not acceptable.
***** Copy of titer laboratory report must be attached.**

Tuberculosis Screening: Required Of All Students

Student Name: _____ DOB: _____

Tuberculosis screening should occur by conducting a risk assessment prior to arrival on campus in conjunction with completion of the admission physical and immunization record. If the answer is **YES** to any of the questions below, student is required to have tuberculin skin testing unless previous positive test has been documented. **If the student is at low risk, a PPD skin test is not required for entrance into college.**

Please answer the following questions:

- Recent close or prolonged contact with someone with or suspected to have active TB? ___Yes ___No
- Were you born in one of the countries/territories listed below that may have a high incidence of active TB disease? ___Yes ___No
  (If yes, please circle the country, below.)

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

- Have you traveled or lived in the countries listed above? __Yes __No. If yes, when?_____ How long were you there?_____.
- HIV Disease ___Yes___No
- Organ Transplant Recipient ___Yes___No
- History of illicit drug use ___Yes___No
- Previous resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, hospitals, homeless shelters or residential facilities for patient with AIDS) ___Yes___No
- Medical condition associated with an increased risk of progressing to TB disease if infected (e.g., diabetes, chronic renal disease, leukemias or lymphomas, Hodgkin's disease, low body weight, chronic malabsorption syndrome, prolonged corticosteroid therapy or immunosuppressive disorder) ___Yes ___No

CERTIFICATION OF HEALTH CARE PROVIDER

Is this student HIGH RISK FOR TB EXPOSURE? (Circle) YES NO

(If **YES**, please **document TB testing on Immunization Record Page 4.** If student has previously tested positive, please **attach chest x-ray report and record of treatment**.)

HEALTH CARE PROVIDER: (Signature required as validation of correct information for TB assessment)

Provider Name:_____Address or Clinic Stamp:_____

Provider Signature:_____ Date:_____

REPORT OF MEDICAL HISTORY *(Please print in black ink)* To be completed by student				
Last Name (print above)	First Name	Middle Name	Date of birth (mo. / day / year)	Davidson ID #

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order; will not be released without your written permission. *Please attach additional sheets for any items that require explanation.*

FAMILY & PERSONAL HEALTH HISTORY *(Please type or print in black ink)* To be completed by student

Has any member of your immediate family (parents, siblings, grandparents) had any of the following?

	Yes	No	Relationship
High Blood Pressure			
Stroke			
Cancer			
Heart disease			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Thyroid disorder			
Respiratory disease			

	Yes	No	Relationship
Blood or clotting disorder			
Alcohol/Drug abuse			
Psychiatric illness			
Suicide			

Have you ever had or have you now? (Please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Pain/pressure in chest			
Heart disease			
Rheumatic fever			
Asthma			
Chronic cough			
Pneumonia			
Shortness of breath			
Tuberculosis			
Dizziness/ fainting spells			
Migraine headaches			
Hay fever /Sinusitis			
Severe Head Injury			
Concussion			
Hearing Loss			
Vision problems			

	Yes	No	Year
Back injury /Recurrent Back Pain			
Neck injury			
Shoulder dislocation			
Broken bones			
Bone/ joint deformity			
Paralysis			
Knee problems			
Arthritis			
Alcohol/drug problem			
Eating Disorder			
Disabling Depression			
Anxiety / panic			
Self-induced vomiting			
Self-injurious behavior			
Obsessive compulsive			
LD/ADD/ADHD			

	Yes	No	Year
Sleep problems			
Frequent vomiting			
Gallbladder or gallstones			
Jaundice			
Hepatitis (please specify)			
Rectal disease			
Severe/recurrent abdominal pain			
Intestinal trouble			
Ulcer (duodenal/stomach)			
Hernia			
Bladder infection			
Kidney infection			
Kidney stone			
Protein or blood in urine			
Pilonidal cyst			
Serious skin disease			

	Yes	No	Year
Anemia/ Low Iron			
Blood transfusion			
Chicken pox			
Diabetes			
Epilepsy /Seizures			
Malaria			
Mononucleosis			
Sexually Transmitted Disease			
Severe menstrual cramps			
Irregular periods			
Sickle Cell Anemia			
Thyroid disorder			
Tumor/ cancer (specify)			
Chemotherapy\ radiation			
Smoking/Tobacco use			
Allergy injection therapy			

□ I would like for someone from the Student Counseling Center to contact me about mental health resources on campus.

□ I would like to meet with a Student Health Center Dietitian. (Services are free of charge.)

Will you be participating on a varsity (NCAA) sports team? □ Yes □ No Which sport? _____

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name Use Dose Name Use Dose

Name Use Dose Name Use Dose

Name Use Dose Name Use Dose

Name Use Dose Name Use Dose

Name Use Dose Name Use Dose

Name Use Dose Name Use Dose

REPORT OF MEDICAL HISTORY continued…				
Last Name (print above)	First Name	Middle Name	Date of birth (mo. / day / year)	Davidson ID #

Have you ever experienced adverse reactions (hypersensitivity, allergies, rash hives, etc.) to any of the following? Check each item "Yes" or "No." If answer "Yes", please describe reaction in the space on the right.

Adverse Reaction to:	Yes	No	Describe Reaction
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies			
May food allergies/special dietary needs be shared with Dining Services?			
Do you require use of an EpiPen for allergic reactions?			NOTE: Vail Commons Dining Hall offers students the opportunity to store an EpiPen on site if student so desires.

Do you have any condition or disability that limits your physical activities? (If yes, please describe.)			
Have you ever been a patient in any type of hospital? Surgeries? (When, where, and why.)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain.)			
Is there loss or seriously impaired function of any paired organs? (Please describe.)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details.)			

IMPORTANT INFORMATION....PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission for Student Health Services to release information from my (son/daughter's) medical record to a physician, hospital, or other medical personnel involved in providing me (him/her) with emergency treatment and/or medical care.
(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Center.
(C) I am aware that the Health Center charges for some services and I will be billed through the Business Services Office. I accept personal responsibility for settling the account with the cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the college is unaffected by the existence of insurance coverage.
(D) If I have elected coverage under the college health insurance policy, I hereby authorize the release of medical information necessary to process insurance claims, and authorize Academic Health Plans or their representatives to pay benefits directly to the Student Health Center for services received.

_____ Date _____
Signature of Student (**REQUIRED)**

_____ Date_____
Signature of Parent/Guardian (if student under age 18 at time of entry)

PHYSICAL EXAMINATION ***(Please print in black ink)*** To be completed and signed by practitioner (**Per NCAA rules M.D. or D.O. (NOT a PA or NP) must sign for a varsity athlete**). A physical examination is required within the past year. **EXCEPTION: Varsity athletes must have a physical within six months of participation or after March 1st.**

Last Name (print above)	First Name	Middle Name	Date of birth (mo./ day / year)	Davidson ID #

Date of Exam: _____Height:_____Weight:_____BMI:____Temp: _____Pulse:_____Resp:_____BP:_____

Urinalysis: Sugar _____Albumin_____Micro_____

Vision: Corrected Right 20/ ____ Left 20/_____
Uncorrected Right 20/_____ Left 20/_____

Hgb or Hct: _____

Color Vision _____

NCAA requires **ALL** varsity athletes to have a hemoglobin solubility (sickle cell trait screening). See page 9.
The **actual lab report** is required; please attach. Alternatively, a copy of the testing done at birth may be attached.

Are there abnormalities? If so, describe in full	NO	YES	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic / Endocrine			
10. Neuropsychiatric			
11 Skin			
12. Mammary			

(Questions below ARE REQUIRED to be completed)

A. Is the patient's current BMI percentile reflective of the pattern since birth? □ Yes □No

B. If the BMI is less than 17 has the patient been evaluated for disordered eating? □ Yes □ No

C: Has this patient experienced significant weight change over the past year? □ Yes □ No

D. Is there loss or seriously impaired function of any paired organs? □Yes □No
If **YES,** please explain_____

E. Is student under treatment for any medical or mental health condition? □Yes □No
If **YES,** please explain _____

F. Recommendation for physical activity (physical education, intercollegiate sports, intramurals, etc.) **Unlimited**_____ **Limited**_____

G. Diet Prescription (please check if applicable): This student requires the following diet prescription:
Dairy-free_____ Nut-free: All nuts_____ Soy-free: _____ Other:_____
Egg-free _____ Tree nuts_____ Shellfish: _____ _____
Gluten-free_____ Peanuts_____ _____

H: Does this student require an EpiPen? □ Yes □ No

_____ _____
Signature of Physician / Physician Assistant / Nurse Practitioner **(M.D. or D.O. only for varsity athletes)** Date

_____ _____/_____
Print Name of Physician/Physician Assistant/Nurse Practitioner **(M.D. or D.O. only for varsity athletes)** Telephone/ Fax Number

_____
Office Address City State Zip Code

ATTENTION: Requirements for All Varsity Athletes

Physical Examination

NCAA rules require that your physical be performed **within 6 months of participation or after March 1st** and that it be performed by a M.D. or D.O. (not a PA or NP).The Student Health Center must have your History & Physical Exam form (completed in its entirety) and your immunization record **before you will be allowed to participate** in any camps or pre-season conditioning activities. **A physical exam done by a parent will not be accepted.**

Sickle Cell Trait Screening

Approximately 2.5 million Americans have sickle cell trait, meaning one copy of the sickle gene. The gene can be present in those with Mediterranean, Middle Eastern, Indian, Caribbean, South & Central American ancestry as well as African-American ancestry. People with sickle-cell trait are at a higher risk for heat-related illness/heat stroke. Knowledge of sickle cell trait status prior to sports participation does not disqualify the athlete from participation; it allows for simple precautions to help prevent complications.

All student-athletes participating in varsity sports are now **required by NCAA** to present evidence of testing for sickle-cell trait. While Sickle Cell Trait screening is normally performed on all babies born in the United States at birth, some student-athletes may not know if they have the trait. If you are unable to obtain documentation of the testing done at birth, please see your personal physician for testing prior to arrival on campus. The physician should include with your admission physical a report of hemoglobin solubility, for example LabCorp test # 005223 or Quest test # 825, both with a CPT code of 85660. Alternatively, a copy of the testing done at birth may be attached.

ADHD Requirements

ADD/ADHD medications are banned by the NCAA; however, an athlete is allowed to remain on this medication if they obtain proper documentation as follows:

Student-Athlete Document Responsibility

The student-athlete's documentation from the prescribing physician to the athletic department/sports medicine staff should contain a minimum of the following information to help ensure that ADHD has been diagnosed and is being managed appropriately:

a. Description of the evaluation process which identifies the assessment tools and procedures.
b. Statement of the diagnosis, including when it was confirmed.
c. History of ADHD treatment (previous/ongoing).
d. Statement that a non-banned ADHD alternative has been **considered** if a stimulant is currently prescribed.
e. Statement regarding follow up and monitoring visits.
f. **Yearly** documentation from treating physician is required.

Please check the NCAA website for more information and details on ADD/ADHD medication (www.ncaa.org, academics & athletes, health & safety, look under "Recently Released, NCAA Drug Testing Medical Exceptions Police-ADHD Reporting Guidelines).

INSURANCE

Each Davidson student **must** have medical insurance, either through a private insurance company plan or the insurance package offered through the college.

All students will see the fee for the college-offered plan (Academic Health Plans/UHC) on their fall tuition bills **every year.** You may review the plan details at **davidson.myahpcare.com.** If you have other health insurance **that provides benefits in the Davidson area** and you do not wish to have the AHP/UHC insurance, **you must complete the on-line insurance waiver no later than August 1.** If the waiver is not completed by **August 1,** you will automatically be enrolled and **WILL be responsible for payment of this premium.**

Please note that this plan DOES NOT provide coverage for intercollegiate sports.

Why does Davidson College require evidence of health insurance?

An unexpected illness or accident can generate the need for specialty care. Expenses can add up and quickly overwhelm a family's financial resources. This could impact your ability to remain in school and progress toward your academic goals. Health insurance helps offset the cost of emergency and specialty care.

What are the policy dates for 2017-2018?

The coverage is effective from August 9, 2017 – August 8, 2018.

How do I make the decision whether or not to waive the college-offered plan?

First you need to determine if your personal/family policy provides benefits **in the Davidson area**. Note that some insurance companies only provide services for emergency care obtained at a hospital or urgent care when you are outside of your home network. You or your parents need to call the Customer Service phone number for your policy and **determine if they will cover care in this area**. Though you may have been previously healthy, there is always the chance that you may at some time during your four years at Davidson have the need for x-rays or other diagnostic tests or need to see a specialist such as a gastroenterologist, an ENT physician or an orthopedist for an injury.

If you currently have Medicaid you will need to remain enrolled in the college-offered plan, unless you have coverage in the Davidson area and intend to obtain your healthcare from your usual provider.

Do I have to complete a waiver each year?

Yes. All students with private insurance coverage will need to complete the online waiver and verify their insurance coverage each year.

Providing insurance information on page 1 of the Student Health physical exam form or providing insurance information to the Athletic Department DOES NOT take the place of completing the online waiver.

NOTE: Though there is no charge for the actual visit with a physician or nurse at the Student Health Center, there are charges for laboratory tests, orthopedic braces, vaccines and some medications. The Student Health Center files insurance claims for students covered by the college policy, but **does not file claims with private insurance companies**. Charges will be placed on your tuition bill. Students can be provided, upon request, a universal claim form to submit to their private insurance company for reimbursement.

Disability Resources

Davidson College values the diversity of its community and is an equal access institution that admits otherwise qualified applicants without regard to disability. The Office of Academic Access and Disability Resources is housed in the Center for Teaching and Learning under the Division of Student Life. The AADR Office works closely with the Dean of Students Office and other college offices and departments to assure that the programs and facilities of the college are accessible to every student in the Davidson College community.

When an otherwise qualified student with a disability is admitted, the college seeks to accommodate those requests that are determined to be reasonable and do not compromise the integrity of a program or curriculum. The College's intention is that every student may, as independently as possible, meet the demands of college life.

Students are not required to disclose their disability status; however, if they are seeking accommodations relative to their disability, they are responsible to submit a written request and to provide the appropriate and most current documentation to the **Academic Access and Disability Resources Office**. A student has the responsibility to meet qualifications and maintain essential Davidson College standards for courses, programs, services, employment, activities, conduct and facilities. Having a disability does not automatically qualify a student to receive accommodations.

The college must review current diagnostic information submitted by the student and through an interactive process, verify that the student has a disability requiring accommodations according to federal law and then determine the specific accommodations the student is authorized to use

Accommodations and supportive services include but are not limited to:

- extended time testing
- testing in a reduced distraction environment
- referrals to outside resources for diagnostics and documentation
- consults for assistive technology
- specific course tutoring
- note taking services
- interpreters
- alternate format texts
- Read and Write Gold software
- course substitutions
- reduced semester course load
- accessible classrooms
- individual supportive counseling
- coaching with regards to study skills
- time management
- self-advocacy skills and managing functional limitations
- consultation with faculty and staff.

Additionally the college has adaptive equipment and assistive technology available to students with disabilities: Kurzweil 1000 and 3000, Read and Write Gold, Livescribe and Kindle. Additional assistive software such as Zoom Text, Kurzweil, Read and Write Gold, Dragon Speak Naturally and other iPad, iPhone, PC and Mac applications are also available through the Disability Resources Office.

If you are a student or a prospective student with a disability and would like to request accommodations or more information about disability resources, **please contact:**

Academic Access and Disability Resources
Center for Teaching and Learning
AADR@davidson.edu
704-894-2129