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/Pronoun _____

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 ( ) _____

Home City_____State_____Zip Code _____

Parents' Names _____

Parents' Employer_____Work Phone ( ) _____

_____ Work Phone ( ) _____

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

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

_____
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

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. Fortunately, the bacteria that cause meningitis are not as contagious as the flu or the common cold, 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. Meningococcal conjugate vaccine (Menactra or Menveo) 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 in not needed. Meningococcal vaccine should be available from your primary care physician or your local Health Department.

The CDC and ACIP (American Council of Immunization Practices) are not currently recommending routine use of serogroup B vaccines (Trumenba or Bexsero) in otherwise healthy college students in settings where there is not a current confirmed outbreak of this disease. The vaccines are recommended for persons age 10 years or older who are at increased risk for serogroup B meningococcal infections, including persons without a spleen, persons with a rare immune system illness called “persistent complement component deficiency”, persons taking the medication Soliris (eculizumab) and microbiologists that work with meningococcal isolates.

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, https://www.cdc.gov/meningococcal/index.html

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), your immunization record and sickle cell test **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).

ATTENTION: Required for All Varsity Athletes

DAVIDSON COLLEGE SPORTS MEDICINE

NAME (PRINT): _____
(Last) (First)

GRADUATION YEAR_____

SPORT: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Davidson College Student Health & Counseling Center & Davidson Sports Medicine Department to release pertinent information from my history or information acquired in the course of my examination or treatment between the two departments for the purpose of advising status and eligibility for returning to sports.

STUDENT SIGNATURE: _____

DATE: _____/_____/_____

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, Local Health Department, Previous College or University, Personal Shot Records which are certified by a doctor's stamp or signature or by a clinic or health department stamp.

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** **1***** **VARICELLA** (Required if born 04/01/01 or after.)	**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. (**2 MMR** doses meet this requirement.) **1**** **RUBELLA** *(German measles)* dose **2**** **MUMPS** **3** **HEPATITIS B** (Required if born 7/1/94 or after.) **1***** **VARICELLA** (Required if born 04/01/01or after.)
Measles and Mumps vaccines are not required if you were <u>born prior to 1957</u>. 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 7) 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 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.

*** Laboratory confirmation of varicella disease immunity, a protective antibody, or documentation from a physician, NP or PA verifying history of disease will be accepted in lieu of the vaccine.

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
• Hepatitis B Series (Required if born 7/1/94 or after) **Blood titer not accepted as proof of immunization.** **OR**	#1	#2	#3	**TITER NOT ACCEPTED**
• Hepatitis B (Heplisav-B, 2-dose series) **OR**	#1	#2		**TITER NOT ACCEPTED**
• Hepatitis A/B combination series	#1	#2	#3	**TITER NOT ACCEPTED**
• Varicella (chicken pox) At least one dose required if born after **04/01/01**, or immunity by positive blood titer, protective antibody titer or disease date.	#1	#2	Disease Date	*** 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	
• Meningococcal (Booster dose recommended at age 16)				
• Hepatitis A series	#1	#2		

SECTION C Optional Immunizations	mo./ day / year	mo./day /year	mo. / day / year
• 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 laboratory report must be attached.**

Tuberculosis Screening *(Please print in black ink)* To be completed by student & healthcare provider				
Last Name (print above)	First Name	Middle Name	Date of birth (mo. / day / year)	Davidson ID #

Tuberculosis (TB) Screening Questionnaire: All new students are required to complete and submit the following TB screening questionnaire form. **The form must be signed by a healthcare provider**.

SECTION A: Tuberculosis (TB) Exposure Risk (to be completed by student):

1. Have you ever had close contact with persons known or suspected to have active TB disease? **YES ____ NO ____**
2. Have you ever lived, worked or volunteered in any homeless shelter, prison/jail or long-term care facility? **YES ____ NO ____**
3. Have you ever been a member of any of the following groups that may have an increase incidence of latent tuberculosis infection or active TB disease: Organ transplant recipient, abuser of alcohol or drugs, HIV positive? **YES ____ NO ____**
4. Were you born in, or have you lived, worked or visited for >1 month in one of the following countries listed below? **YES ____ NO ____**

IF YES, where? _____ How long? _____ Dates visited/lived_____

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

Source: World Health Organization Global Health Observatory. Tuberculosis Incidence 2017. Countries with incidence rates of? 20 cases per 100,000

SECTION B: FOR HEALTHCARE PROVIDER TO COMPLETE:

Clinicians should review and verify the information above. Persons answering **YES** to any of the questions in the TB SCREENING are required to have TB testing, [either tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA)], unless a previous positive test has been documented. For previous positive tests, please send test results, CXR results and if applicable, documentation of treatment. Anyone with a positive TB Skin test or IGRA with no signs of active disease on chest x-ray should receive recommendation to be treated for latent TB.

Tuberculin Skin Test: Date administered___ /____/____ Date read: _____/____/_____ Result:_____ mm
OR
Tuberculin Blood Test: Date ___/____/____ Result: _____

If TB test is positive: Chest x-ray is REQUIRED: Date done: ____/____/____ Normal ☐ Abnormal ☐ (**must attach radiology report**)

Provider Name:_____Address/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/Special dietary needs			
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 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: **REQUIRED OF ALL STUDENTS**. To be completed and signed by practitioner. 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. Per NCAA rules M.D. or D.O. (NOT a PA or NP) must perform physical for varsity athletes**.

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 (if indicated): Sugar_____Albumin_____ Micro_____

Vision: Corrected Right 20/_____Left 20/_____
Uncorrected Right 20/_____Left 20/_____ Hgb or Hct (if indicated): _____
Color Vision _____

NCAA requires **ALL** varsity athletes to have a hemoglobin solubility (sickle cell trait screening). See page 3. 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

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 health insurance plan 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 college-offered health 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.**

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.

Please note that this plan will now provide coverage for intercollegiate sports.

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.

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 2019-2020?

The coverage is effective from August 9, 2019 – August 8, 2020.

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.

Do I have to complete a waiver each year?

Yes. All students with private insurance coverage who do not wish to keep the insurance offered by the college **will need to complete the online waiver and verify their insurance coverage each year**.

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
704-894-2294