

HEALTH EVALUATION FORM

I. HEALTH HISTORY- To be completed by the STUDENT (Required of all full-time students)

Please answer all questions. Information requested in this form is strictly for the use of the Health Center in providing medical care and will not be released without your consent. Information gathered will not affect your status in any way.

Name _____ Age _____ Birthday ____/____/____ Sex _____
Last First MI
Student ID V# _____ Sports _____

Home Address _____
Street Apt City State Zip Code
Home phone: (____) _____ Cell phone: (____) _____
Name of parent(s) or guardian: _____

Anticipated entry date: Spring _____ Fall _____ Previously enrolled: Yes _____ No _____
Admission Status First-Year Transfer Readmission Graduate

In Case of Emergency, notify: _____ Relationship: _____
Address: _____
Street Apt City State Zip Code
Name of insurance company: _____ Subscriber: _____
Policy Number: _____ Address: _____

PERSONAL HISTORY

Significant Medical Conditions (dates and diagnoses): _____
Hospitalizations (dates and diagnoses): _____
Please **circle** to indicate whether you have (or had in the past) these problems.

- | | | | |
|---------------------------|----------------------------|------------------------|----------------------------------|
| Allergies | Hearing impairment | Migraine headache | Sexually transmitted disease |
| Anemia | Heart Disease | Pneumonia | Substance/alcohol abuse |
| Asthma | Heart murmur | Psychological problems | Thyroid disorder |
| Bleeding disorder | Hepatitis or liver disease | Rheumatoid arthritis | Tuberculosis or positive TB test |
| Cancer or malignancy | High blood pressure | Rheumatic fever | Visual impairment |
| Chickenpox | HIV | Sickle Cell Trait | Other |
| Diabetes | Kidney infection or stone | Sickle Cell Disease | |
| Gastrointestinal Disorder | Lung disease | Seizure disorder | |

FAMILY HISTORY: Check if condition exists in your family (immediate family, grandparents, aunts, uncles, and cousins).

- | | | | |
|-------------------|---------------|----------------------|--------------|
| Allergies | Cancer | High Blood Pressure | Sudden death |
| Anemia | Diabetes | Lung Disease | Tuberculosis |
| Asthma | Eye disorder | Psychiatric disorder | Ulcer |
| Bleeding disorder | Heart disease | Stroke | Other |

FOR SIGNATURE OF PARENTS/LEGAL GUARDIANS OR STUDENTS 18 YEARS OF AGE OR OLDER

Virginia law requires parental permission in order to provide medical or surgical care to minors. Parents/legal guardian must sign the following consent statement to ensure medical care is carried out promptly without unnecessary delays. **RELEASE OF MEDICAL RECORDS: I authorize the release of all medical records to Virginia State University Student Health Center.**

I hereby authorize the physicians, clinicians, and staff nurses of Virginia State University Student Health Center to examine, interview, test, and if necessary, treat my son/daughter/myself, as deem advisable.

Signature: _____ Date: ____/____/____
Parent, guardian or student

IMPORTANT NOTICE: Failure to comply with the Commonwealth Of Virginia Immunization laws will result in a Student Health HOLD being placed on your registration for the upcoming semester.

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II. PHYSICAL EXAMINATION: To be completed by THE LICENSED HEALTH PROFESSIONAL (M.D., P.A., N.P.) PERFORMING THE EVALUATION. Please review the student's history (Part I), and provide additional details as needed. Please complete the physical exam and comment on all positive findings.

Name _____ SID V# _____
Last First Middle

HEIGHT: _____ WEIGHT: _____ lbs. BP _____ Pulse _____ Vision R 20/ _____ L 20/ _____

Please record findings below. If abnormal please elaborate.

Examination findings	Normal	Abnormal	Examination findings	Normal	Abnormal
Head, Ear, Nose, Throat			Genitourinary		
Eyes			Back		
Respiratory			Extremities		
Cardiovascular			Skin		
Breasts			Surgical scars		
Gastrointestinal			Metabolic/Endocrine		
Hernia			Neuropsychiatric		

Abnormal findings:

RECOMMENDED:

Hct or Hgb: _____ Sickle Cell test (if indicated): _____ Urine: Alb. _____ Glu. _____ Micro. _____

REQUIRED (Please check)

DIAGNOSIS: Excellent health with no chronic medical problems **OR**

Other diagnosis and recommendation-Please list _____

PHYSICAL ACTIVITY: Unlimited: Limited (explain): _____

Allergies to Medications: _____

Current Medications and Doses: _____

Examiners Signature: _____ **Date of Exam:** ____/____/____

Print Name: _____

Address: _____

PHONE: (OFFICE) (_____) _____ FAX: (_____) _____

HEALTH EVALUATION FORM

III. IMMUNIZATION RECORD: - To be completed and signed by THE HEALTH CARE PROVIDER.

Name _____ SID V# _____
Last First Middle

PLEASE ATTACH COPY OF IMMUNIZATION RECORD(S). All information must be in English.

REQUIRED IMMUNIZATIONS

MMR (Measles, Mumps, Rubella)

Two doses live vaccine at or 12 months of age, at least on month apart.

Dose 1 ____/____/____

Dose 2 ____/____/____

DIPHTHERIA/PERTUSSIS/TETANUS (DPT)

1. Primary childhood series date completed ____/____/____
2. Tetanus/Diphtheria: Td or Tdap (circle) within last 10 years ____/____/____

POLIO SERIES: Primary childhood series date completed ____/____/____

MENINGOCOCCAL VACCINE: Menomune or Menactra (circle) ____/____/____

HEPATITIS B VACCINE

(Series of 3 vaccines)

Dose 1 ____/____/____

Dose 2 ____/____/____

Dose 3 ____/____/____

TUBERCULOSIS SCREEN within last 12 months

Mo Day Yr

PPD is strongly recommended, however, CDC guidelines allow the following screening alternative:

TB Risk Assessment: If the answer is YES to any of the questions below a Tuberculin Skin test is REQUIRED. If NO to all the answers below, student is considered low risk and no further evaluation is needed.

1. Has the student ever had a positive TB skin test? Yes ___ No ___
2. Has the student ever had close contact with anyone who was sick with TB? Yes ___ No ___
3. Was the student born outside of the United States? Yes ___ No ___
4. Has the student ever been vaccinated with BCG? Yes ___ No ___
5. Has the student traveled outside of the country within the last 5 years? Yes ___ No ___
What country or countries? _____

If YES to any of the above, PPD REQUIRED. PPD (Mantoux) within the past 12 months.

Placement Date: ____/____/____ Date of reading: ____/____/____

Results: ____ mm (provide actual size) Negative ____ Positive ____

****IF PPD IS POSITIVE, CHEST X-RAY AND COPY OF REPORT REQUIRED.**

To the best of my knowledge, this person received the above immunizations.

Signature of Health Professional: _____ Date: ____/____/____

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HEALTH EVALUATION FORM

Meningitis & Hepatitis B Vaccine Information Form

Name: _____ SID V#: _____
Date of birth: ____/____/____

Meningitis

Meningitis is an infection of the fluid of the spinal cord and brain, caused by a virus or bacteria and usually spread through exchange of respiratory and throat secretions (i.e., coughing, kissing). Bacterial meningitis can be quite severe and may result in brain damage, hearing loss, or learning disability. A vaccine is currently available that effectively provides immunity for most types of bacterial meningitis, the more serious form, but there is no vaccine for viral type.

Waiver of Liability:

I have received and read the information pertaining to meningitis. Despite the fact that I understand the risks involved, I refuse to receive the meningitis vaccine.

Signature of Student (or parent/legal guardian, if under 18 years of age) Date: ____/____/____

Signature of Witness Date: ____/____/____

Hepatitis B

Hepatitis B is a viral infection of the liver caused primarily by contact with blood and other body fluids from infected persons. Hepatitis B vaccine can provide immunity against hepatitis B infection for persons at significant risk, including people who have received blood products containing the virus through transfusions, drug use, tattoos, or body piercing; people who have sex with multiple partners or with someone who is infected with the virus; and health care workers and people exposed to biomedical waste.

Waiver of Liability:

I have received and read the information pertaining to hepatitis B. Despite the fact that I understand the risks involved, I refuse to receive the hepatitis B vaccine.

Signature of Student (or parent/legal guardian, if under 18 years of age) Date: ____/____/____

Signature of Witness Date: ____/____/____

Note: Virginia State University assumes no liability for individuals electing not to be vaccinated for Meningitis or Hepatitis B.

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