Virginia State University Student Health Center
P.O. Box 9082, Petersburg, Virginia 23806 Phone (804) 524-5711 Fax (804) 524-5026

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:** _____ **Phone No**._____
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

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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:

_____

_____

Hct or Hgb: _____ Sickle Cell test (required for athletes): _____Urine: Alb. ___Glu. ____Micro. _____

REQUIRED (Please check)

DIAGNOSIS: Excellent health with no chronic medical problems ☐ OR

Other diagnosis and recommendation-Please list ☐ _____

REQUIRED (Please check)

PHYSICAL ACTIVITY: Unlimited: ☐ Limited (explain): ☐ _____

Allergies to Medications: _____
Current Medications and Doses: _____

Examiners Signature: _____Date of Exam: ____/_____/____
Print Name: _____
Address: _____
PHONE: (OFFICE) (_____) _____ FAX: (_____) _____

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HEALTH EVALUATION FORM

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

Name_____ SID V#_____
Last First Middle

Date of birth: _____/_____/_____

Please attach copy of immunization records(s)

		Month	Day	Year
Required by law	Polio series completed yes no Last booster			
Required by law	Diphtheria/Tetanus/Pertussis completed primary series			
Required by law	Tetanus toxoid/diphtheria or Tdap (within ten years)			
Required by law: on or after first birthday	MMR (dose 1)			
Unless born prior to 1957	**OR**			
	Measles vaccine (dose 1)			
	Mumps			
	Rubella			
	AND			
Required by law	MMR (dose 2) (given at least one month after dose 1)			
	OR			
	Measles vaccine (dose 2)			
	OR			
	Titer: Please provide copy of report.			
Required by law	Hepatitis B: Completion date.			
Required by law	Meningococcal vaccine or waiver**: Within 5 years (not HIB)**			
	Meningococcal vaccine booster			

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

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

OR

__The physical condition of the above named individual is such that immunization could endanger life or health.

Signature of Health Professional: _____ Date: _____

Printed Name: _____ Phone: ( ) _____

Address: _____ Fax: ( ) _____

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IV. TUBERCULOSIS SCREENING – TO BE COMPLETED AND SIGNED BY THE LICENSED HEALTH PROFESSIONALS (MD., PA., NP., RN) PERFORMING THIS EVALUATION.

The following are the revised tuberculosis screening requirements at Virginia State University. These are revised to reflect the updated recommendations published by the Centers for Disease Control in the MMWR, Vol. 49, June 9, 2000. Please answer all questions and sign below.

NAME:_____ **SID V#:**_____
Last First Middle

All answers must be indicated on this form before it is considered complete, incomplete forms will be returned.

1. **Traveled to Asia, Africa, Latin America, Eastern Europe, or Russia within the last 5 years? Yes:_____ No:_____**
2. **Has the student had close contact with persons known or suspected of having tuberculosis? Yes:_____ No:_____**
3. **Volunteered, been employed or been a resident of a correctional institution, nursing home, mental institution, homeless shelter or other long-term care facility serving high-risk clients? Yes:_____ No:_____**
4. **Has the student been exposed to a household contact that meets any of the criteria numbers 2-5? Yes:_____ No:_____**
5. **Was the student born outside of the United States? Yes:_____ No:_____**

Date of PPD ___/___/___ Date of reading ___/___/___Result: _____mm (provide actual size in mm, not just positive/negative) (Within last 12 months)

- **If PPD, past or present, is positive-Chest x-ray is REQUIRED within the last 12 months:**
- **Result: _____**
- **Treatment (medication prescribed and duration of treatment) _____**
- **Any follow-up recommendations? _____**

Examiner's Signature _____

Date_____

PPD IS REQUIRED IF ANY OF THE FOLLOWING RESPONSES ARE YES.

ALL SECTIONS OF THIS FORM (I, II, III, AND IV) MUST BE COMPLETED AND RETURNED TO THE

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HEALTH EVALUATION FORM

STUDENT HEALTH SERVICE. INCOMPLETE FORMS WILL BE RETURNED.

Meningitis & Hepatitis B Vaccine Information Form

Name: _____ SID V#: _____
Last First MI

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.

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

_____ Date: _____/_____/_____
Signature of Witness

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.

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

_____ Date: _____/_____/_____
Signature of Witness

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

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