Health Evaluation Checklist

Please be sure the following information is complete **before submitting the Health Evaluation Form**. This is required of all full-time students; including transfer students regardless of classification and is due **June 1st** for fall admission and **December 1st** for students entering in the spring.

SECTION I - HEALTH HISTORY

- ☐ Health History
- ☐ Student Identification Number (V#)
- ☐ Home Address
- ☐ Emergency Contact Information
- ☐ Personal History
- ☐ Did you sign and date your form?
- ☐ Are you under the age of 18? If so, be sure you parent/guardian signs the health form.
- ☐ Have you attached a photocopy of your Insurance I.D. Card?

SECTION II - PHYSICAL EXAMINATION

- ☐ Has your physician/clinician completed every item on the Health Evaluation form? (Including vital signs, diagnosis and recommendation for physical activity)
- ☐ Signature of physician/clinician, address, phone number, professional stamp and date of physical?

SECTION III - IMMUNIZATION RECORD

- ☐ Is a photocopy of immunization records attached?
- ☐ Are all immunization dates documented?
- ☐ 1st and 2nd MMR? – Both dates are required.
- ☐ Tetanus Diphtheria or Tdap – within ten (10) years?
- ☐ Polio (OPV) AND DIPHTHERIA/TETANUS/PERTUSSIS (DTP) – date of last in series.
- ☐ Hepatitis B - Dose #1
- ☐ Hepatitis B - Dose #2
- ☐ Hepatitis B - Dose #3
- ☐ Hepatitis Waiver
- ☐ Meningitis Vaccine
- ☐ Meningitis Booster
- ☐ Meningitis Waiver

SECTION IV - TUBERCULOSIS SCREENING

- ☐ TB Screening or TB skin test
- ☐ Signature and date of health care provider

HELPFUL HINTS FOR A COMPLETED FORM

- Follow the Health Evaluation Checklist to ensure all information is included
- Ensure your name and Student V# is written on all forms and any attached documents
- Remember to take your Health Evaluation Form to your physical exam visit
- Bring a copy of your immunization (shot) records to your exam visit (so provider can complete section III)
- Before leaving exam visit, ensure provider has signed and dated sections II, III and IV
- Make a copy of completed Health Evaluation Form for your record prior to submitting form.

It is important for you to answer each section of the health record completely. Incomplete forms will result in a HOLD on your account and delay your registration process. If you have questions regarding the completion of these forms, please call Student Health Services at (804) 524-5711, Monday - Friday, 8:00 a.m. - 5:00 p.m.

Mail or fax completed health form to:

Virginia State University
Student Health Center
P.O. Box 9082
Virginia State University, VA 23806
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 admission status in any way.
These forms are due **June 1st** for fall admission and **December 1st** for students entering in the spring.

Name Last Name (Last) First Name (First) MI (MI) Date of Birth ____/____/____ Gender Select

Student V# Enter Number VSU Sport (if applicable) Enter Sport

Home Address Enter Street Address (Street Address) Apt (Apt) City (City) State (State) Zip Code (Zip Code)

Home phone (Enter) Home Phone Cell Phone (Enter) Cell Phone

Name of parent(s) or guardian: Enter Name of Parent(s) or Guardian

Anticipated entry date: Spring _____ Fall _____ Previously enrolled? ☐ Yes ☐ No

Admission Status ☐ First-time Freshman ☐ Transfer ☐ Re-Admit ☐ Graduate

In Case of Emergency, notify: Enter Emergency Contact Relationship: Relationship

Address Address (Address) Apt (Apt) City (City) State (State) Zip Code (Zip Code) Phone: (Phone Number)

Name of Insurance Company: Enter Insurance Company Subscriber: Enter Subscriber
(Please provide a photocopy of your insurance I.D. Card in addition to information completed above)

Policy Number: Enter Policy Number Address: Enter Address

PERSONAL HISTORY

Significant Medical Conditions (dates and diagnoses): Please Enter

Hospitalizations (dates and diagnoses): Please Enter

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: Circle 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

Health Evaluation Form

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. DO NOT LEAVE ANY FIELDS BLANK, instead write "N/A" or "not examined".

Name Enter Last Name (Last) Enter First Name (First) MI (MI) Student V# Enter Number

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

Please record findings below. If abnormal, please elaborate.

Examination findings	Normal	Abnormal	Not Examined	Examination findings	Normal	Abnormal	Not Examined
Head, Ear, nose, Throat				Genitourinary			
Eyes				Back			
Respirator				Extremities			
Cardiovascular				Skin			
Breasts				Surgical Scars			
Gastrointestinal				Metabolic/Endocrine			
Hernia				Neuropsychiatric			

Abnormal findings: _____

_____

Hct or Hgb: _____ *Sickle Cell test: _____ *Urine: Alb. _____ Glu. _____ Micro. _____

*Required for all sports. Attach a copy of lab results

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:_____

Examiner's Signature: _____ Date of Exam: _____/_____/_____

Printed Name: _____

Address: _____

Phone: (Office) (_____)_____ Fax: (_____)_____

Health Evaluation Form

III. IMMUNIZATION RECORD - To be completed and signed by the LICENSED HEALTH PROVIDER.

All *full-time* students are required by the Code of Virginia (Section 23-7.5) to provide documentation of their immunizations by a licensed health professional. If you are unable to provide appropriate documentation, vaccines may be repeated.
A registration hold for the upcoming semester will be placed if all required immunizations are not up-to-date.

Name _____ Student V#_____
Last First MI

Date of Birth: _____/_____/_____

	Month	Day	Year
REQUIRED IMMUNIZATIONS			
POLIO *date of last dose or booster*			
DIPHTHERIA/TETANUS/PERTUSSIS (DPT) *completed primary series*			
TETANUS TOXOID/DIPHTHERIA (Td) or Tdap *within ten years*			
MMR (*dose 1) Initial dose after 1st birthday (unless born prior to 1957)*			
MMR (*dose 2) Given at least 1 month after dose 1*			
or **MMR TITER** *Please provide copy of report*			
RECOMMENDED OR WAIVER			
Hepatitis B *Completion date*			
MENINGOCOCCAL VACCINE			
MENINGOCOCCAL VACCINE BOOSTER *if 1st dose before 16th birthday*			
Meningitis B *(dose 1)*			
Meningitis B *(dose 2)*			

PLEASE ATTACH COPY OF IMMUNIZATION RECORD

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.**

Signatureof Health Professional: _____ Date: _____/_____/_____

Printed Name: _____ Phone: (_____)_____

Address: _____ Fax: (_____)_____

Health Evaluation Form

IV. TUBERCULOSIS SCREENING - To be completed by the LICENSED HEALTH PROFESSIONAL (M.D., P.A., N.P., R.N., L.P.N.) PERFORMING THE EVALUATION ONLY. Licensed health professional must sign and date.

The following are the revised tuberculosis screening requirements at Virginia State University. These are revised to reflect the updated recommendations published by the CDC. Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. MMWR November 2005; 54 (No. RR-12): 4-5.

Please answer all questions and sign below.

PPD IS ONLY REQUIRED IF ANY OF THE FOLLOWING RESPONSES ARE YES.
(Licensed health professional must sign and date)

Name _____ Student V#_____
Last First MI

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 _____/_____/_____

ALL SECTIONS OF THIS FORM (I, II, III, AND IV) MUST BE COMPLETED AND RETURNED TO THE STUDENT HEALTH CENTER. INCOMPLETE FORMS WILL BE RETURNED.

Health Evaluation Form

V. MENINGITIS & HEPATITIS B VACCINE INFORMATION

Name _____ Student 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.