I. Health History – *To be completed by the student. (Required of all students)*

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

Please print clearly in black ink:

VUU Student ID_____ Date of Birth _____ Age_____ Gender _____

Name _____
Last First Middle

Address _____
Street Apt. #

_____
City State Zip

_____ _____ _____
Home Phone Cell Phone Name of parent(s) or guardian

In case of emergency, notify _____ Relationship _____
Address _____ Phone _____
Name of insurance company _____ Subscriber_____
Policy number _____ Address_____

Personal History Significant Medical Conditions (dates and diagnoses):

Hospitalizations (dates and diagnoses): _____

Please check to indicate whether you have (or had in the past) these problems.

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

Family History

Check if any of the following conditions exists in your family (immediate family, grandparents, aunts, uncles, and cousins).

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Eye disorder
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Lung disease
- ☐ Psychiatric disorder
- ☐ Stroke
- ☐ Sudden death
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ 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 Union University Student Health Services. I hereby authorize the physicians, clinicians, and staff nurses of Virginia Union University Student Health Services to examine, interview, test, and if necessary, treat my son/daughter/myself, as deem advisable.

Signature _____ Date_____

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.

Please print clearly in black ink:

Name _____ VUU Student ID _____

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		
Mammary			Surgical scars		
Gastrointestinal			Metabolic/endocrine		
Hernia			Neuropsychiatric		

Abnormal findings:

_____

_____

RECOMMENDED

Hct or Hgb _____ Sickle Cell test (athletes only) _____ Urine _____ Alb. _____ Glu. _____ Micro. _____

REQUIRED (Please check)

DIAGNOSIS

☐ Excellent health with no chronic medical problems ☐ 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 _____

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

III. Immunization Record – *To be completed by the Healthcare Provider.*

Please print clearly in black ink:

Name _____ VUU Student ID _____

Date of Birth _____

Please attach a copy of immunization record(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 1 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: Within 5 years (not HIB)			
	Varicella series			

Please attach a copy of immunization record(s). All information must be in English.

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

OR

☐ The physical condition of the above name individuals is such that immunization could endanger life or death.

Signature of Health Professional _____ Date _____

Print Name_____ Address _____

Phone (OFFICE) _____ Fax _____

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

IX. Tuberculosis Screening – *the Licensed Health Professional (M.D., P.A., N.P.) performing the evaluation.*

The following are the revised tuberculosis screening requirements at Virginia Union 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.

Please print clearly in black ink:

Name _____ VUU Student ID _____

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 _____

Print Name_____ Phone (OFFICE) _____

PPD IS REQUIRED IF ANY OF THE ABOVE RESPONSES ARE YES

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

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

MENINGITIS & HEPATITIS B VACCINE INFORMATION

10D

Please print clearly in black ink:

Name _____ VUU Student ID _____

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)

_____ Date _____

Signature of Witness

HEPATITIS B

Hepatitis B is a viral infection of the liver caused primarily by contact with blood and other bodily 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)

_____ Date _____

Signature of Witness

NOTE: Virginia Union University assumes no liability for individuals electing not be vaccinated for Meningitis or Hepatitis B.

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

Return forms to:

Virginia Union University
Attn: Office of Student Health Services
1500 North Lombardy Street
Richmond, Virginia 23220