HEALTH EVALUATION FORM

I. Health History – To be completed by the student. (Required of all students)
Please answer all questions. Information requested in 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 ______________________
City______________ State__________ Zip__________ Subscriber______________________
Name of insurance company ______________________ Address ______________________
Policy number ______________________ City__________ State__________ Zip__________

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 deemed advisable.

Signature____ Date____________________

Virginia Union University
1500 North Lombardy Street | Richmond, Virginia 23220

Office of Student Health Services
Telephone: 804.313.6045
Fax: 804.257.5622

HEALTH EVALUATION FORM

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
Head, Ear, Nose, Throat		
Eyes		
Respiratory		
Cardiovascular		
Mammary		
Gastrointestinal		
Hernia		

Examination Findings	Normal	Abnormal
Genitourinary		
Back		
Extremities		
Skin		
Surgical scars		
Metabolic/endocrine		
Neuropsychiatric		

Abnormal finding:

____

____

RECOMMENDED

Hct or Hgb __________ 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.

HEALTH EVALUATION FORM

III. Immunization Rec- 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			
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)			
Required by law	OR			
	Measles vaccine (dose 2)			
Required by law	Hepatitis B: Completion date			
Required by law	Meningococcal vaccine: (MCV4) Within 5 years. If last dose was received before the age of 16, revaccination is required.			
	Varicella series: 2 doses or history of disease			
	Varicella series: (dose 2)			

Please attach documentation of religious exemption from any of the required immunizations. All information must be in English.

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

OR

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

Please provide titer results for any immunizations that you can not show proof of receiving.

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.

HEALTH EVALUATION FORM

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. Has the student traveled to Asia, Africa, Latin America, Eastern Europe, or Russia within the last 5 years? ☐ Yes ☐ No
2. Has the student had close contact the persons known or suspected of having tuberculosis? ☐ Yes ☐ No
3. Has the student 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? ☐ Yes ☐ No
5. Was the student born outside of the United States? ☐ Yes ☐ No

PPD IS REQUIRED IF ANY OF THE ABOVE RESPONSES ARE YES

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: (Quantiferon results are also accepted)

Result (please attach copy) ______________________________

Treatment (medication prescribed and duration of treatment) ______________________________

Any follow-up recommendations? ______________________________

Examiner's Signature ______________________________ Date ______________

Print Name______________________________ Phone (OFFICE) ______________

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

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 face 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

Office of Student Health Services
Telephone: 313.6045
Fax: 804.257. 5622