# Medical Record

**Deadline June 1 (Fall Semester) and December 1 (Spring Semester) of the current enrollment year**

## Part I

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<tbody>
<tr>
<td>1.</td>
<td>LAST</td>
<td>FIRST</td>
<td>MIDDLE</td>
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<td>3.</td>
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<td>4.</td>
<td>HOME ADDRESS</td>
<td>5.</td>
<td>DATE OF BIRTH</td>
<td>6.</td>
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<td>7.</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP</td>
<td>8.</td>
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<tr>
<td>10.</td>
<td>FAMILY PHYSICIAN – NAME AND ADDRESS</td>
<td>9.</td>
<td>TELEPHONE NO.</td>
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## Part II

**School Status:**

- [ ] Undergraduate
- [ ] Graduate
- [ ] Division of Continuing Studies
- [ ] College of Va. Beach

### Parental Permit

The law requires that parental permission be obtained for procedures on minors. In order for a minor to be treated by the Health Center, the following consent form should be signed by the parent or legal guardian so that such treatment may be promptly carried out, and so that no unnecessary delays will occur with operative procedures. However, no operation will be performed, except in an extreme emergency, without the parents being contacted and fully informed!

I give permission for such diagnostic, therapeutic, and operative procedures as may be deemed necessary for my son / daughter (cross out one).

Signed ______________________________________________

Relationship __________________________________________

I do / do not (cross out one) carry hospitalization, sickness and accident insurance for my son / daughter. *

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<tr>
<td>Insurance Company or Agent</td>
<td>Name of Policy Holder</td>
<td>Company Address</td>
<td>ID/Group Policy Number</td>
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* If you do not have proper insurance for the above named applicant, the college will provide insurance and add the premium to the college bill unless you specifically state otherwise.

**Do you have any chronic diseases? If so, please list:** __________________________________________________________

**Do you take any medications daily? If so, please list:** __________________________________________________________

11. Indicate any of the following complaints you have had with any frequency *(Please check)*:

- [ ] Abdominal Cramps
- [ ] Headaches
- [ ] Nervousness
- [ ] Shortness of Breath
- [ ] Backache
- [ ] Indigestion
- [ ] Night Sweats
- [ ] Sinus Trouble
- [ ] Fainting Spells
- [ ] Weight Loss
- [ ] Persistent Cough
- [ ] Skin Trouble

12. Give any special details that you consider important concerning treatment and recovery in connection with the diseases and complaints checked under Question No. 11. __________________________________________________________

13. Please describe any prior or current treatment by a mental health provider such as psychiatrist, psychologist or counselor:

_________________________________________________________________________________________________

14. Do you have any food or medication allergies? If so, please explain:

_________________________________________________________________________________________________

**IMPORTANT: The University requires each student to take physical education.**

15. Do you have any physical defects, deformities or other conditions which limit your physical activities? If so, please specify:

_________________________________________________________________________________________________

16. Do you require the use of a wheelchair, crutches, or other ambulatory aids? If so, please specify: ______________________

_________________________________________________________________________________________________

I certify that the foregoing statements are true to the best of my knowledge. I realize that falsification of the provided information is a violation of the University Code of Conduct and could result in sanctioning by a hearing panel.

Date ___________________________ Signature ___________________________
# PHYSICAL EXAMINATION

**MUST BE COMPLETED ON UNIVERSITY FORM ONLY**

*(TO BE COMPLETED BY EXAMINER)*

## PART III – CLINICAL EVALUATION

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>CHECK EACH ITEM IN APPROPRIATE COLUMN. ENTER NE IF NOT EVALUATED.</th>
<th>ABNORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOTES: DESCRIBE EACH ABNORMALITY. ENTER ITEM NUMBER BEFORE EACH COMMENT.</td>
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<tr>
<td>1. HEAD, FACE, NECK AND SCALP</td>
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<td>2. NOSE</td>
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<td>3. MOUTH AND THROAT</td>
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<td>4. EARS–GENERAL</td>
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<td>5. EYES–GENERAL</td>
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<td>6. CHEST–GENERAL</td>
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<td>7. LUNGS</td>
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<td>8. BREASTS</td>
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<td>9. CARDIOVASCULAR SYSTEM</td>
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<tr>
<td>10. ABDOMEN (INCLUDE HERNIAS)</td>
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<td></td>
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<tr>
<td>11. GENITALIA</td>
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<td></td>
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<tr>
<td>12. UPPER EXTREMITIES</td>
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<td></td>
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<tr>
<td>13. LOWER EXTREMITIES</td>
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<td></td>
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<tr>
<td>24. SPINE</td>
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<td>25. SKIN AND LYMPHATICS</td>
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<tr>
<td>16. NEUROLOGIC EXAM</td>
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</table>

## PART IV – LABORATORY

17. URINALYSIS:
   - A. SPECIFIC GRAVITY* |
   - B. MICROSCOPIC* |
   - C. ALBUMIN |
   - D. SUGAR |
   - E. SERUM BUN |
   - F. SERUM CREATININE |
   - G. UREA NITRGEN |
   - H. GLUCOSE |
   - I. PROTEIN |
   - J. LEUKOCYTES |
   - K. RBC |
   - L. UROBILINOGEN |
   - M. HEMOGLOBIN |
   - N. HEMATOCRIT |
   - O. HEPATITIS B |
   - P. HBsAg |
   - Q. HCV |
   - R. HIV |
   - S. T. B. TEST (CHEST X-RAY IF INDICATED) |
   - T. OTHER TESTS – SICKLE CELL *

18. OTHER TESTS – SICKLE CELL *

## PART V – MEASUREMENTS AND OTHER FINDINGS

21. HEIGHT |
22. WEIGHT |
23. COOPER’S PULSE |
24. CORR. TO 20/20 |
25. CORR. TO 20/20 |
26. CORR. TO 20/20 |
27. REMARKS AND PERTINENT HISTORY RELATED TO P.E. FINDINGS

## PART VI – SUMMARY

28. SUMMARY OF DEFECTS AND DIAGNOSIS (PLACE SUPPORTING ITEM NUMBERS BY DIAGNOSIS)

29. RECOMMENDATIONS – FURTHER SPECIALIST EXAMINATIONS INDICATED (SPECIFY)

30. EXAMINEE (CHECK ONE)
   - IS QUALIFIED FOR PHYSICAL EDUCATION, SWIMMING AND ROTC
   - IS NOT QUALIFIED FOR PHYSICAL EDUCATION, SWIMMING AND ROTC
   - SHOULD BE PLACED IN RESTRICTED PHYSICAL EDUCATION CLASS
   - SHOULD WITHDRAW FROM COLLEGE

**Typed or printed name of reviewing physician (designate MD or DO)**

**Signature (Examiner) (MD, DO, NP, PA)**

**Date**

*if indicated

**PHYSICAL EXAMINATION MUST BE COMPLETED ON UNIVERSITY FORM ONLY**
IMMUNIZATION RECORD

*Immunity is required prior to registration. Please complete and return this form.

NAME ____________________________

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER (Dates must include month and year.)

*A. TETANUS-DIPHTHERIA

1. □ Completed primary series of tetanus-diptheria immunizations .............................................
2. □ Received tetanus-diptheria booster (required every 10 years).............................................
3. □ Tdap (preferred) to replace single dose of Td for booster immunization with at least five years since last dose of Td..........................................

*B. M.M.R. (Measles, Mumps, Rubella)

1. □ Dose 1 – Immunized at 12 months or after and before 5 years ...........................................
2. □ Dose 2 – Immunized at 5 years or later .............................................................................

*C. MEASLES (Rubeola) – if given instead of MMR. Check appropriate box.

1. □ Had disease; confirmed by office record ..............................................................................
2. □ Born before 1957 and therefore considered immune...........................................................
3. □ Has report of immune titer. Specify date of positive titer. ....................................................
4. □ Immunized with live measles vaccine at 12 months after birth or later. ...............................

*D. RUBELLA – if given instead of MMR. Check appropriate box.

1. □ Has report of immune titer. Specify date of positive titer ......................................................
2. □ Immunized with vaccine at 12 months after birth or later. ....................................................

*E. MUMPS – if given instead of MMR. Check appropriate box.

1. □ Had disease; confirmed by office record ..............................................................................
2. □ Has report of immune titer. Specify date of positive titer. ....................................................
3. □ Immunized with vaccine at 12 months after birth or later. ....................................................

F. TUBERCULOSIS – Interpretation based on mm of induration. Check appropriate box.

*(Required of International Students Only)

1. □ PPD (Mantoux) test within the past year (Tine or monovac not acceptable)
   Give date placed .................................................Date
   Give date read and results (based on millimeters).................................................................Date
   Result: □ Positive □ Negative
   ________ mm
2. □ Positive PPD – Chest x-ray required.
   Give date and result of chest x-ray .........................................................Date
   Result: □ Positive □ Negative
3. □ Had BCG vaccine – Chest x-ray required if PPD not done ....Date

*G. POLIO

1. □ Completed primary series of polio immunization .............................................................. □ Yes □ No
   Type of vaccine: □ Oral □ Inactivated □ E-IPV
   Last booster..........................................................................................................................

*H. MENINGOCOCCAL MENINGITIS

1. □ MENOMUNE - One dose before entry into college (students with immunodeficiency such as complement deficiency or asplenia should receive vaccine every 3-5 years) ................................
2. □ Menactra - (Conjugate) ........................................................................................................

I. □ HEPATITIS B VACCINE SERIES (REQUIRED OR WAIVER)

HEALTH CARE PROVIDER

Name________________________________________________ Address ______________________________________

Signature_____________________________________________ Phone (____) ___________________________________