CONFIDENTIAL **CONFIDENTIAL**

HAMPTON UNIVERSITY

STUDENT HEALTH SERVICES
Hampton, VA 23668
(757) 727-5315

MEDICAL RECORD

DEADLINE JUNE 1 (FALL SEMESTER) AND DECEMBER 1 (SPRING SEMESTER) OF THE CURRENT ENROLLMENT YEAR

PART I

1. NAME *LAST* *FIRST* *MIDDLE*		2. DATE	3. SEX
4. HOME ADDRESS *CITY* *STATE* *ZIP CODE*		5. DATE OF BIRTH	6. SOCIAL SECURITY NO.
7. PLACE OF BIRTH	8. NAME, RELATIONSHIP AND ADDRESS OF NEXT OF KIN		9. TELEPHONE NO.
10. FAMILY PHYSICIAN – NAME AND ADDRESS			

PART II

PARENTAL PERMIT

The law requires that parental permission be obtained for procedures on minors. In order for a minor to be treated by the Student Health Services, 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. *

Company and Agent ______________________________

Address ______________________________

Policy Number ______________________________

* 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.

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
- ☐ Loss of Weight
- ☐ 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. Do you have any food or medication allergies? If so, please explain: ______________________________

____

IMPORTANT: The College requires each student to take physical education, including swimming.

14. Do you have any physical defects, deformities or other conditions which limit your physical activities? ______________

Specify ______________________________

I certify that the foregoing statements are true to the best of my knowledge.

Date ______________________ Signature ______________________

PHYSICAL EXAMINATION

(TO BE COMPLETED BY PHYSICIAN)

NAME

LAST	FIRST	M. I.

PART III – CLINICAL EVALUATION

NOR-MAL	CHECK EACH ITEM IN APPROPRIATE COLUMN. ENTER *NE* IF NOT EVALUATED.	ABNOR-MAL	NOTES: DESCRIBE EACH ABNORMALITY. ENTER ITEM NUMBER BEFORE EACH COMMENT.
	1. HEAD, FACE, NECK AND SCALP		
	2. NOSE		
	3. MOUTH AND THROAT		
	4. EARS–GENERAL		
	5. EYES–GENERAL		
	6. CHEST–GENERAL		
	7. LUNGS		
	8. BREASTS		
	9. CARDIOVASCULAR SYSTEM		
	10. ABDOMEN (*INCLUDE HERNIAS*)		
	11. GENITALIA		
	12. UPPER EXTREMETIES		
	13. LOWER EXTREMETIES		
	24. SPINE		
	25. SKIN AND LYMPHATICS		
	16. NEUROLOGIC EXAM		

PART IV – LABORATORY

17. URINALYSIS: A. SPECIFIC GRAVITY*

B. ALBUMIN

C. SUGAR

D. MICROSCOPIC*

18. T. B. TEST (*CHEST X-RAY IF INDICATED*)

19. SEROLOGY*

☐ CHECK IF DRAWN

20. OTHER TESTS – SICKLE CELL*

PART V – MEASUREMENTS AND OTHER FINDINGS

21. HEIGHT

22. WEIGHT

23. COLOR OF EYES

24. DISTANT VISION

RIGHT 20/ CORR. TO 20/ TO 20/

LEFT 20/ CORR. TO 20/ TO 20/

OTHER MEASUREMENTS*

25. HEARING (GROSS)*

RIGHT /15

LEFT /15

26. BLOOD PRESSURE *

PULSE

PART VI – SUMMARY

27. REMARKS AND PERTINENT HISTORY RELATED TO P. E. FINDINGS

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	SIGNATURE (*PHYSICIAN*)	DATE

* if indicated

IMMUNIZATION RECORD

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

NAME ______ LAST ______ FIRST ______ M. I.

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 .... MONTH YEAR
2. ☐ Received tetanus-diptheria booster (recommended every 10 years) .... MONTH YEAR

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

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

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

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

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

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

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

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

F. TUBERCULOSIS – Check appropriate box. *(Required of International Students Only) MONTH YEAR Result: ☐ Positive ☐ Negative

1. ☐ PPD (Mantoux) test within the past year (Tine or monovac not acceptable)
   Give date and test results ....Date MONTH YEAR Result: ☐ Positive ☐ Negative
2. ☐ Positive PPD – Chest x-ray required.
   Give date and result of chest x-ray ....Date MONTH YEAR 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 MONTH YEAR
   Type of vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV
   Last booster ....

***H. MENINGOCOCCAL –** One dose before entry into college (students with immuno-deficiency such as complement deficiency or asplenia should receive vaccine every 3-5 yrs)

I. ☐ QUADRIVALENT POLYSACCHARIDE VACCINE .... MONTH YEAR

HEALTH CARE PROVIDER

Name ______ Address ______

Signature ______ Phone (____) ______

SHS (Revised 2/02)