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 _____ Date of Birth ____/____/____ Gender ____
Last First MI

Student V#_____ VSU Sport (if applicable)_____

Home Address _____
Street Address Apt City State Zip Code

Home phone (_____)_____ Cell Phone (_____)_____

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: _____ Relationship: _____

Address_____ Phone: (_____)_____
Address Apt City State Zip Code

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

Policy Number: _____ Address: _____

PERSONAL HISTORY
Significant Medical Conditions (dates and diagnoses): _____

Hospitalizations (dates and diagnoses): _____

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 _____ Student V# _____
Last First MI

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

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 and title: _____ 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, booster,or titer. Please provide copy of report.*			
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, or titer*			
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.**

***Information Above Transcribed from Vaccination/Medical record. Signature:_____Date:_____**

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 ACHA: Tuberculosis Screening and Targeted Testing of College and University Students, 2024. https://www.acha.org/wp-content/uploads/2024/06/ACHA_Tuberculosis_Screening_May2024.pdf.

Please answer all questions 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 within the last 12 months: ____/____/____ Date of reading: ____/____/____

Result: ____ mm (provide actual size in mm; not just positive/negative)

- If PPD, past or present, is positive-Chest x-ray is REQUIRED within the last 12 months:
- Result of Chest XRay: _____
- 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 UPLOADED TO THE MEDICAT PATIENT PORTAL

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.