CONFIDENTIAL **CONFIDENTIAL**

HAMPTON UNIVERSITY

55 E. Tyler Street
HEALTH CENTER
Hampton, VA 23668 • (757) 727-5315

MEDICAL RECORD

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

PART I

1. NAME *LAST* *FIRST* *MIDDLE*	2. DATE *(MM/DD/YY)*	3. SEX	4. CONTACT PHONE NO.
5. HOME ADDRESS CITY STATE ZIP	6. DATE OF BIRTH *(MM/DD/YY)*	7. SOCIAL SECURITY NO.	
8. HAMPTON UNIVERSITY ID NO.	9. NAME, RELATIONSHIP AND ADDRESS OF EMERGENCY CONTACT	10. TELEPHONE NO. OF EMERGENCY CONTACT	
11. FAMILY PHYSICIAN – NAME AND ADDRESS			

PART II

School Status: ☐ Undergraduate ☐ Graduate ☐ Division of Continuing Studies ☐ College of Va. Beach ☐ Re-Admit

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. *

Insurance Company or Agent _____

Name of Policy Holder _____

Company Address _____

ID/Group Policy Number _____

*** If you do not have adequate insurance for the above named applicant, the university will provide insurance and add the premium to the student's account unless you provide proof of adequate coverage.**

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

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

12. 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

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

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

_____

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

_____

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

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

_____

17. 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 *(MM/DD/YY)* _____ Signature _____

PHYSICAL EXAMINATION

MUST BE COMPLETED ON UNIVERSITY FORM ONLY

(TO BE COMPLETED BY EXAMINER)

NAME _____ *LAST* _____ *FIRST* _____ *M. I.*

PART III – CLINICAL EVALUATION

CHECK EACH ITEM IN APPROPRIATE COLUMN. ENTER *NE* IF NOT EVALUATED.	NORMAL	ABNORMAL	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			
14. SPINE			
15. SKIN AND LYMPHATICS			
16. NEUROLOGIC EXAM			

PART IV – LABORATORY

17. URINALYSIS: A. SPECIFIC GRAVITY ✻ B. ALBUMIN C. SUGAR

D. MICROSCOPIC ✻

18. CHEST X-RAY IF INDICATED ✻

19. SEROLOGY ✻

☐ CHECK IF DRAWN

20. OTHER TESTS – Hgb Electrophoresis ✻

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/

25. HEARING (GROSS) ✻

RIGHT /15

LEFT /15

26. BLOOD PRESSURE

PULSE

OTHER MEASUREMENTS ✻

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 ***(DESIGNATE MD OR DO)***

SIGNATURE ***(EXAMINER) (MD, DO, NP, PA)***

DATE ***(MM/DD/YY)***

✻ if indicated

HC (Revised 08/12)

PHYSICAL EXAMINATION MUST BE COMPLETED ON UNIVERSITY FORM ONLY

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-DIPTHERIA *(Required)

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

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

1. ☐ Dose 1 – Immunization date required at exactly 12 months or after and before 5 years ..... MONTH DATE YEAR
2. ☐ Dose 2 – Immunized at 5 years or later ..... MONTH DATE YEAR

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

1. ☐ Has report of immune titer. **Specify date and send copy of positive results.** ..... MONTH DATE YEAR
2. ☐ Immunized with live measles vaccine at 12 months after birth or later. ..... MONTH DATE YEAR

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

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

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

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

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) Result: ☐ Positive ☐ Negative
   Give date placed.....Date MONTH DATE YEAR
   Give date read and results (based on millimeters).....Date MONTH DATE YEAR _____ mm
2. ☐ Positive PPD – Chest x-ray required. Result: ☐ Positive ☐ Negative
   Give date and result of chest x-ray .....Date MONTH DATE YEAR
3. ☐ Had BCG vaccine – Chest x-ray required if PPD not done .....Date MONTH DATE YEAR

G. POLIO *(Required)

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

H. MENINGOCOCCAL MENINGITIS *(Required)

1. ☐ MENOMUNE - **Immunization and updates as per CDC guidelines.** ..... MONTH DATE YEAR
2. ☐ Menactra - (Conjugate) **Immunization and updates as per CDC guidelines.** ..... MONTH DATE YEAR

I. ☐ HEPATITIS B VACCINE SERIES *(RECOMMENDED OR WAIVER)* ..... MONTH DATE YEAR MONTH DATE YEAR MONTH DATE YEAR

***(Required for Health Care Profession Students)**

HEALTH CARE PROVIDER

Name _____ Address _____

Signature _____ Phone (____) _____