

# HAMPTON UNIVERSITY

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## Special Program - Medical Clearance Form

Name of Special Program \_\_\_\_\_

Start Date of Special Program \_\_\_\_\_ HU ID# (if applicable) \_\_\_\_\_

### PLEASE PRINT OR TYPE

**PERSONAL** Date: \_\_\_\_\_

Name \_\_\_\_\_  
*Last First Middle Initial*

Address \_\_\_\_\_  
*Number Street City State Zip Code*

Telephone Number (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
*Area Code*

#### Name and relationship of emergency contact

Name \_\_\_\_\_  
*Last First Middle Initial*

Relationship \_\_\_\_\_ Telephone Number (\_\_\_\_\_) \_\_\_\_\_  
*Area Code*

#### PARENTAL CONSENT FOR MINORS

I give my consent for \_\_\_\_\_ to receive the medical care available to Special Program students. In the event that emergency treatment is required and I am not available, I give my consent for the program director, their representative or other HU official (i.e., Health Center, V.P. for Student Affairs, etc.) to approve of necessary treatment and/or hospitalization. I understand that such treatment will be at my expense.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Parent(s)/Guardian(s)*

Insurance Provider \_\_\_\_\_ Policy Number/Subscriber Name \_\_\_\_\_ Group Number \_\_\_\_\_

The following questions are designed to protect YOUR HEALTH.

#### Personal History (Check all that apply)

A. Have you ever had (or have now):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Racing of heart or palpitations |
| <input type="checkbox"/> Severe headaches          | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Asthma                          |
| <input type="checkbox"/> Fainting or near fainting | <input type="checkbox"/> Wheezing or coughing | <input type="checkbox"/> Depression/Anxiety              |

B. List any frequently taken medicines (prescribed or over the counter):  \_\_\_\_\_

C. Do you have any food or medication allergies? If so, please explain. \_\_\_\_\_

#### Past History (Check all that apply) Have you ever been told of having or advised of any of the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart murmur(s)               | <input type="checkbox"/> Sickle cell trait or anemia | <input type="checkbox"/> Heat exhaustion          |
| <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Severe sprains              | <input type="checkbox"/> Fractures                |
| <input type="checkbox"/> Heart failure                 | <input type="checkbox"/> Marfan's Syndrome           | <input type="checkbox"/> Severe ligament injuries |
| <input type="checkbox"/> Kidney disease                | <input type="checkbox"/> Concussion                  | <input type="checkbox"/> Other lung disease       |
| <input type="checkbox"/> Protein or blood in the urine | <input type="checkbox"/> Other head injuries         | <input type="checkbox"/> _____                    |
| <input type="checkbox"/> Other heart disease           | <input type="checkbox"/> Asthma                      |   |

#### Family History (Check all that apply) Has any parent, grandparent, sister or brother had any of the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Died before age 50 (cause if known) _____ | <input type="checkbox"/> Heart attack                | <input type="checkbox"/> Heart failure    |
| <input type="checkbox"/> High blood pressure                       | <input type="checkbox"/> Sickle cell trait or anemia | <input type="checkbox"/> Marfans syndrome |
|  | <input type="checkbox"/> Diabetes                    |   |

Signature \_\_\_\_\_  
*Participant/Guardian*

**PHYSICAL EXAMINATION**  
**MUST BE COMPLETED ON UNIVERSITY FORM ONLY**  
*(TO BE COMPLETED BY EXAMINER)*

Name \_\_\_\_\_  
*Last*
*First*
*Middle Initial*

Height \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Weight \_\_\_\_\_ Pulse \_\_\_\_\_

Normal	Check in appropriate column. <i>(Enter NE if not evaluated)</i>	Abnormal	Notes: Describe abnormality. <i>(Enter item number before each comment.)</i>
	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 extremities		
	13. Lower extremities		
	14. Spine		
	15. Skin and lymphatics		

16. Remarks and pertinent history related to P.E. findings (Place supporting item numbers by diagnosis)

17. Recommendations – Further specialist examinations indicated (specify)

18. **Examinee** (*check one*)

is qualified for athletic participation

is not qualified for athletic participation

<b>Typed or printed name of reviewing physician</b>	<b>Signature (examiner) (MD, DO, NP, PA)</b>	<b>Date</b>
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# IMMUNIZATION RECORD

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

Name \_\_\_\_\_  
Last
First
Middle Initial

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

**\*A. TETANUS-DIPHTHERIA (Required)**

- 1.  Completed primary series of tetanus-diphtheria immunizations ..... 

MONTH	DATE	YEAR		
- 2.  Received tetanus-diphtheria 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. MMR (Measles, Mumps, Rubella) (Required) – Two doses required at least 28 days apart.**

- 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. 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 

MONTH	DATE	YEAR		

  
 Give date read and results (based on millimeters) ..... Date 

MONTH	DATE	YEAR		

 \_\_\_\_\_ mm
- 2.  Positive PPD – Chest x-ray required or IGRA results (Please Attach).  
 Give date and result of chest x-ray ..... Date 

MONTH	DATE	YEAR		

 Result:  Positive  
 Negative
- 3.  Had BCG vaccine – Chest x-ray required if PPD not done or IGRA results (Please Attach). 

MONTH	DATE	YEAR		

**\*D. POLIO**

- 1.  Completed primary series of polio immunization .....  Yes  No 

MONTH	DATE	YEAR		

  
 Type of vaccine:  OPV  IPV  
 Last booster ..... 

MONTH	DATE	YEAR		

**\*E. MENINGOCOCCAL MENINGITIS TETRAVALENT (Required A, C, Y, W-135 Groups)**

One dose must be given at age 16 or later.  
 All adolescents and teens ages 11-18 should be vaccinated, as should unvaccinated adults who are attending college.  
 Requirements are based on current CDC guidelines.

**A booster dose is required for those who received their first dose before age 16:**

- Menactra ..... 

MONTH	DATE	YEAR		

  
 or
- Menveo ..... 

MONTH	DATE	YEAR		

  
 or
- Menomuune ..... 

MONTH	DATE	YEAR		

- \*F.  **HEPATITIS B (Required or Must Sign Waiver)** ..... 

MONTH	DATE	YEAR		

  

MONTH	DATE	YEAR		

  

MONTH	DATE	YEAR		

  

MONTH	DATE	YEAR		

**Hepatitis B Waiver:** I have reviewed the CDC website regarding Hepatitis B @ <http://www.cdc.gov/hepatitis/index.html> and have been fully informed of the risks and health hazards of Hepatitis B infection as well as the benefits of the Hepatitis B vaccine. I choose not to be immunized against the Hepatitis B infection at this time. I am aware that the shot is available at my local health department or retail pharmacy. Student signature (if under 18, parent or guardian must sign here):

Signature \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH CARE PROVIDER**

Name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_