University of the Virgin Islands

STUDENT HEALTH FORM

***ALL HEALTH DOCUMENTS MUST BE COMPLETED AND UPLOADED TO THE HEALTH HUB PORTAL:* (https://uvi.medicatconnect.com)**

Contact Information: Health Services Center

Albert A. Sheen Campus (St. Croix)
RR#1 Box 10, 000 Kingshill
St. Croix, VI 00850-9781
(340) 692-4208 (Office)

Orville E. Kean Campus (St. Thomas)
#2 John Brewers Bay
St. Thomas, VI 00802-9990
(340) 693-1124 (Office)

INSTRUCTIONS:

1. Visit the Medicat portal **(https://uvi.medicatconnect.com)** and complete the
   a. UVI Health History form
   b. Texting Opt-in-Opt-Out form
   c. Enter the immunization dates on immunization tab
   d. Upload all health records including your physical exam, PPD (tuberculin skin test), and proof of vaccinations.
2. If you are under 18 years of age, a parent or guardian MUST complete and sign the Medical Consent Section of this Student Health Form.
3. Have a licensed medical provider (NP, MD, DO, or PA) fill out the physical examination section of this form including the required laboratory tests results.

MEDICAL CONSENT (to be completed by the parent or guardian)

I, the undersigned (parent or guardian) do hereby grant permission to the University of the Virgin Islands Health Service Center (personnel, medical providers and nurses, or the medical provider designated by the campus physician) to provide medical and or surgical treatment to:

____
NAME OF CANDIDATE FOR ADMISSION

during her/his enrollment at the University of the Virgin Islands. I also grant permission for her/his hospitalization and treatment herein, if such hospitalization is necessary.

I understand that in the event of a serious illness, accidental injury or need for surgery, an attempt will be made by the University's Health Service Center to contact me by telephone. If unable to contact me, emergency treatment may be given as necessary in the best interest of the student.

____ ______________________________
SIGNATURE OF PARENT OR GUARDIAN / DATE
SIGNATURE OF STUDENT (IF OVER 18 YEARS OLD) / (Month / Day/ Year)

(Physical Examination section to be completed by a medical provider)

PHYSICAL EXAMINATION SECTION

Student Name ________________________________**DOB** _____/_____/_________**Female** ____**Male**

Height _______**Weight** ______lbs. **BMI**_______**Blood Pressure** _____/_____**T** ____**P** ______**R** ____

Distance Vision: Right uncorrected: 20 /____Right corrected 20 / _____

Left uncorrected: 20 / ____Left corrected 20 / _____

Color Vision: _____normal _____abnormal

Hearing (whispered voice at 10 feet): Right _____heard _____not heard

Left _____heard _____not heard

ALLERGIES: ______________________________________**SYMPTOMS:** __________________________

SYSTEMS	NL	ABNL	NA	COMMENTS:
HEENT				
HEART				
LUNGS				
ABDOMEN				
EXTREMITIES				
NEURO				
SKIN				
GENITAL(General PR Only)				

CURRENT MEDICATIONS:

Name of Medication(s)	Dosage	How Often	Discontinued
1.			
2.			
3.			

CURRENT MEDICAL CONDITION(S) AND TREATMENT(S):

____

____

SURGICAL & PAST MEDICAL HISTORY:

____

____

ADDENDUM:

____

____

(Physical Examination section to be completed by a medical provider)

IMMUNIZATIONS: Required for all students
Please upload proof of all vaccines, lab results, and PPD test results to the Health Hub on the upload tab

Polio:___/___/____ ___/___/____ ___/___/____ (3 doses acceptable)
Tetanus, Diphtheria, Pertussis: Primary series completed? Yes_____No _____ Date of last dose in series: ____/____/____

Date of most recent booster dose: ____/____/_____ **Type of booster:** Td_____Tdap _____

MMR: ____/____/_________/____/_____

Hepatitis B:___/___/______/___/_______/___/____

Meningococcal Quadrivalent (ACYW-135): __/__/__

****If Meningococcal ACYW is received before the age of 16, you will need an additional dose of the vaccine for residential living __/__/____**

Varicella: (A history of chicken Pox, a positive varicella antibody or 2 doses of vaccines meet the requirement):

Dose #1 ____/____/_____ Dose #2 ____/____/_____ 1. History of Disease: Year ________or age _________

2. Varicella antibody Date __/___/_____ Result Reactive ______non-Reactive_____

PPD Skin Test is required for ALL students every 2 years. (Yearly for Nursing students in Clinicals).

PPD or TST (Tuberculin Skin Test) ____/____/_____ PPD Reading: ____/____/_________ mm Negative Positive

CXR Results (required for positive PPD): _________ ☐ INH Treatment rec'd _____3 mos. _____6 mos. _____9 mos.

LABORATORY TEST RESULTS: CBC: ______________UA: ______________FBS: ______________☐ Lab Slip Given

According to my review of systems, history, and physical examination of the student:

______She/He/They are fit for any form of physical

______She/He/They should be excused from participation in strenuous physical activity

______She/He/They should be excused from participation in all forms of physical activity

____ ____________________________

MEDICAL PROVIDER NAME *(Please Print)* **SPECIALITY AREA**

MEDICAL PROVIDER'S SIGNATURE: ____________________________________

DATE: _____________
(Month/ Day / Year)

MEDICAL PROVIDER'S ADDRESS: ____
____
____

UVI MEDICAL PROVIDER'S SIGNATURE: ______________________________________DATE: _____________
(Month/ Day / Year)