Student Health Form

PHYSICAL EXAMINATION
(To be completed by medical provider)

HEALTH FORM MUST BE COMPLETED AND RETURNED TO THE UNIVERSITY’S HEALTH SERVICE CENTER PRIOR TO MOVING ON CAMPUS OR RegisterING FOR CLASSES.

MAILTO ADDRESS SHOWN AT THE BOTTOM OF PAGE 4

INSTRUCTIONS:
1. Complete Sections I and II by providing the requested information (all students 18 years of age and older).
2. If you are under 18 years of age, a parent or guardian MUST complete and sign Sections I and II.
3. Have any licensed medical provider fill out Section III including the required laboratory test.

I. INFORMATION

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE INITIAL</th>
<th>DATE OF BIRTH (mo / day / year)</th>
<th>SEX</th>
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<thead>
<tr>
<th>RESIDENTIAL ADDRESS</th>
<th>STREET RURAL ROUTE</th>
<th>CITY</th>
<th>ISLAND / STATE</th>
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<table>
<thead>
<tr>
<th>MAILING ADDRESS (IF DIFFERENT FROM ABOVE)</th>
<th>ZIP CODE</th>
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<tbody>
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<table>
<thead>
<tr>
<th>PARENT OR GUARDIAN NAME</th>
<th>HOME PHONE</th>
<th>BUSINESS PHONE</th>
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<thead>
<tr>
<th>PARENT OR GUARDIAN RESIDENTIAL ADDRESS (IF DIFFERENT FROM ABOVE)</th>
<th>STUDENT E-MAIL ADDRESS</th>
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II. 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) and/or surgical treatment to:

______________________________
NAME OF CANDIDATE FOR ADMISSION

I understood 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, needed emergency treatment may be given as necessary in the best interest of the student.

______________________________
SIGNATURE OF PARENT OR GUARDIAN

DATE (mo / day / year)

______________________________
SIGNATURE OF STUDENT (IF OVER 18 YEARS OLD)

PLEASE PRINT CLEARLY

Revised July 2014
**Patient Medical History Information**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>DO YOU HAVE OR HAVE YOU EVER HAD:</th>
<th>YES</th>
<th>NO</th>
<th>DO YOU HAVE OR HAVE YOU EVER HAD:</th>
<th>COMMENTS (Office Use Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Eye trouble <em>(exclude glasses, contact lenses)</em></td>
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<td></td>
<td>31. Frequent or painful urination</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>2. ANY allergies:</td>
<td></td>
<td></td>
<td>32. Blood, protein, or sugar in urine</td>
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<td></td>
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<td>3. Take any medications regularly</td>
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<td>33. History of diabetes</td>
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<td></td>
<td></td>
<td>4. Frequent, severe, or migraine headaches</td>
<td></td>
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<td>34. Kidney stone</td>
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<td></td>
<td></td>
<td>5. Fainting or dizzy spells</td>
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<td>35. Hernia or rupture</td>
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<td></td>
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<td>6. Periods of unconsciousness</td>
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<td></td>
<td>36. Back pain or trouble</td>
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<td></td>
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<td>7. Head injury or skull fracture</td>
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<td></td>
<td>37. Paralysis or weakness</td>
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<td>8. Epilepsy, seizures or convulsions</td>
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<td>38. Foot trouble / use orthotics</td>
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<td></td>
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<td>9. Loss of memory <em>(amnesia)</em></td>
<td></td>
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<td>39. Rheumatic fever</td>
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<td></td>
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<td>10. Depression, anxiety or nervousness</td>
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<td></td>
<td>40. Any bone or joint problem or injuries</td>
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<td></td>
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<td>11. Any mental condition or illness</td>
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<td></td>
<td>41. Tuberculosis or positive TB test</td>
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<td></td>
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<td>12. Hearing loss</td>
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<td></td>
<td>42. Sexually transmitted disease <em>(STD)</em></td>
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<td></td>
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<td>13. Ear, nose, or throat trouble</td>
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<td>43. Any skin conditions</td>
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<td></td>
<td></td>
<td>14. Sinusitis or sinus trouble</td>
<td></td>
<td></td>
<td>44. Adverse reactions to vaccines / drugs</td>
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<tr>
<td></td>
<td></td>
<td>15. Hay fever or allergic rhinitis</td>
<td></td>
<td></td>
<td>45. Adverse reactions to food / insect bites</td>
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<td></td>
<td></td>
<td>16. Tooth/gum trouble or current orthodontics</td>
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<td>46. Sensitivity to chemical, dust, sunlight, etc.</td>
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<td></td>
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<td>17. Thyroid trouble</td>
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<td>47. Eating disorder</td>
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<td></td>
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<td>18. Chronic cough or lung disease</td>
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<td>48. Recent gain or loss of weight</td>
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<td></td>
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<td>19. Asthma or wheezing</td>
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<td>49. Excessive bleeding or easy bruising</td>
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<td></td>
<td></td>
<td>20. Unusual shortness of breath</td>
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<td>50. Tumor, growth, cyst, or cancer</td>
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<td></td>
<td></td>
<td>21. Pain or pressure in chest</td>
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<td>51. Considered or attempted suicide</td>
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<td>22. Palpation or pounding heart</td>
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<td>52. Learning disability or speech problems</td>
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<td>23. High blood pressure</td>
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<td>53. Had ANY surgery</td>
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<td></td>
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<td>24. Heart trouble or heart murmur</td>
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<td>54. Any other injury or illness not noted above</td>
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<td>25. Stomach, liver, or intestinal problem</td>
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<td>55. Had a change in menstrual pattern</td>
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<td></td>
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<td>26. Gallbladder trouble or gallstones</td>
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<td>56. Been treated for a female disorder</td>
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<td></td>
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<td>27. Hepatitis <em>(yellow jaundice)</em></td>
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<td>57. Experience painful periods or cramps</td>
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<td>28. Hemorrhoids or rectal disease</td>
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<td>58. Have you ever been pregnant</td>
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<td>29. Black or bloody stools</td>
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<td>59. Are you currently pregnant</td>
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<td>30. Constipation / Diarrhea</td>
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I grant permission for the personnel of the UVI Health Service Center (HSC) to examine and treat me for the reasons I have presented. I agree to be responsible for all charges incurred. I hereby authorize my insurance benefits to be paid directly to UVI Health Service Center. I authorize the release of any information required to process any insurance claim or any report required by a municipality or governmental agency. I also agree to be responsible for payment of services including those not covered by my school insurance (students only) and/or insurance company, including; late fees and collection costs.

**Signature** (Parent/Guardian must sign if under 18 years old)  
**Date** (mo / day / year)
III. PHYSICAL EXAMINATION (to be completed by a medical provider)

Student Name ___________________________________  DOB ___/___/_____  ___Female  ___Male

Height _______  Weight _______ lbs  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: __________________________

<table>
<thead>
<tr>
<th>SYSTEMS</th>
<th>NL</th>
<th>ABNL</th>
<th>NA</th>
<th>Comments:</th>
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<tbody>
<tr>
<td>HEENT</td>
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<td>HEART</td>
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<td>LUNGS</td>
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<td>ABDOMEN</td>
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<td>EXTREMITIES</td>
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<td>NEURO</td>
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<td>SKIN</td>
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<td>GENITAL</td>
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CURRENT MEDICATIONS:

<table>
<thead>
<tr>
<th>Name of Medication(s)</th>
<th>Dosage</th>
<th>How Often</th>
<th>Discontinued</th>
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CURRENT TREATMENT(S):

SURGICAL & PAST MEDICAL HISTORY:

ADDENDUM:
IMMUNIZATIONS: Required for all students

Polio: ___/___/___ ___/___/___ ___/___/___ (3 doses are acceptable)

Tdap: ___/___/___ (Get a Tdap Vaccine once then TD booster every 10 years)

TD: ___/___/___ ___/___/___ ___/___/___

MMR: ___/___/___ ___/___/___

Hepatitis B: ___/___/___ ___/___/___ ___/___/___

Meningococcal: ___/___/___

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 2. Varicella antibody Date ___/___/___ Result Reactive _____ Non-Reactive____

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

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

CXR Results (required for positive PPD): _________ ☐ INH Treatment Received: ___ 3 months ___ 6 months ___ 9 months

LABORATORY TEST RESULTS: CBC: ____________ UA: ____________ FBS: ____________ ☐ Lab Slip Given

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

_____ She/He is fit for any form of physical activity

_____ She/He should be excused from participation in strenuous physical activity

_____ She/He should be excused from participation in all forms of physical activity

MEDICAL PROVIDER NAME (Please Print) ________________________

SPECIALITY AREA

MEDICAL PROVIDER’S SIGNATURE: ___________________________________ DATE: ______________________ (mo / day / year)

MEDICAL PROVIDER’S ADDRESS: ____________________________________________

________________________________________________________________________

________________________________________________________________________

UVI MEDICAL PROVIDER’S SIGNATURE: _______________________________ DATE: ______________________ (mo / day / year)

UNIVERSITY OF THE VIRGIN ISLANDS

St. Croix Campus
Health Service Center
RR#1 Box 10, 000 Kingshill
St. Croix, VI 00850-9781
(340) 692-4208 (Office)
(340) 692-4225 (Fax)

St. Thomas Campus
Health Service Center
#2 John Brewers Bay
St. Thomas, VI 00802-9990
(340) 693-1124 (Office)
(340) 693-1211 (Fax)
Name: ________________________________ Date of Birth: _______ Gender: M / F

Date: _________________ Time: _______ Student Status: ☐ FT ☐ PT

**TUBERCULOSIS (TB) SCREENING/TESTING**

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)

- Afghanistan
- Côte d'Ivoire
- Democratic People's Republic of Korea
- Democratic Republic of the Congo
- Djibouti
- Ecuador
- El Salvador
- Equatorial Guinea
- Eritrea
- Estonia
- Madagascar
- Gabon
- Malawi
- Marshall Islands
- Ghana
- Mauritania
- Guatemala
- Mauritius
- Guinea
- Mexico
- Guinee-Bissau
- Micronesia (Federated States of)
- Haiti
- Mongolia
- Honduras
- Morocco
- India
- Mozambique
- Indonesia
- Myanmar
- Iran (Islamic Republic of)
- Namibia
- Iraq
- Nauru
- Kazakhstan
- Nepal

Nicaragua
- South Africa
- Niger
- South Sudan
- Nigeria
- Sri Lanka
- Niue
- Sudan
- Pakistan
- Suriname
- Palau
- Swaziland
- Panama
- Tajikistan
- Papua New Guinea
- Thailand
- Paraguay
- Timor-Leste
- Peru
- Togo
- Philippines
- Trinidad and Tobago
- Poland
- Tunisia
- Portugal
- Turkey
- Qatar
- Turkmenistan
- Kenya
- Uganda
- Russia Federation
- United Republic of
- United States
- Rwanda
- Tanzania
- República de
- Saint Vincent and the Grenadines
- Sao Tome and Principe
- Senegal
- Vanuatu
- Serbia
- Venezuela (Bolivarian Republic of)
- Seychelles
- Viet Nam
- Sierra Leone
- Yemen
- Singapore
- Zambia
- Somalia
- Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to [http://apps.who.int/ghodata](http://apps.who.int/ghodata).

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? ☐ Yes ☐ No

(If yes, CHECK the countries, above)

If you have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ☐ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? ☐ Yes ☐ No

*The significance of the travel exposure should be discussed with a health care provider and evaluated.*

If the answer is YES to any of the above questions, [insert your college/university name] requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).

If the answer to all of the above questions is NO, no further testing or further action is required.

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*The American College Health Association has published guidelines on “Tuberculosis Screening and Targeted Testing of College and University Students.” To obtain the guidelines, visit [http://www.acha.org/Publications/Guidelines_WhitePapers.cfm](http://www.acha.org/Publications/Guidelines_WhitePapers.cfm).*