To whom it may concern:

Norfolk State University complies with the code of Virginia (23-7.5, shown below) which requires all full-time students to provide documentation of health history and immunizations.

23-7.5. Health histories required; immunizations.

A. No full-time student shall be enrolled for the first time in any four-year, public institution of higher education in this Commonwealth unless he has furnished, before the beginning of the second semester or quarter of enrollment, a health history consistent with guidelines adopted by each institution's board of visitors, pursuant to the requirements of this section. Any student who fails to furnish the history will not be eligible for registration for the second semester or quarter. Any student who objects on religious grounds shall be exempt from the health history requirement set forth in this section.

B. The health history shall include documented evidence, provided by a licensed health professional or health facility, of the diseases for which the student has been immunized, the numbers of doses given, the dates when administered and any further immunizations indicated. Prior to enrollment, all students shall be immunized by vaccine against diphtheria, tetanus, poliomyelitis, measles (rubeola), German measles (rubella), and mumps according to the guidelines of the American College Health Association.

C. In addition to the immunization requirements set forth in subsection B, all incoming full-time students, prior to enrollment in any public four-year institution of higher education, shall be vaccinated against (i) meningococcal disease and (ii) hepatitis B.

However, if the institution of higher education provides the student or, if the student is a minor, the student's parent or other legal representative, detailed information on the risks associated with meningococcal disease and hepatitis B and on the availability and effectiveness of any vaccine, the student or, if the student is a minor, the student's parent or other legal representative may sign a written waiver stating that he has received and reviewed the information on meningococcal disease and hepatitis B and the availability and effectiveness of any vaccine and has chosen not to be or not to have the student vaccinated.

D. Any student shall be exempt from the immunization requirements set forth in this section who (i) objects on the grounds that administration of immunizing agents conflicts with his religious tenets or practices, unless an emergency or epidemic of disease has been declared by the Board of Health, or (ii) presents a statement from a licensed physician which states that his physical condition is such that administration of one or more of the required immunizing agents would be detrimental to his health.

E. The Board and Commissioner of Health shall cooperate with any board of visitors seeking assistance in the implementation of this section.

F. Further, the State Council of Higher Education shall, in cooperation with the Board and Commissioner of Health, encourage private colleges and universities to develop a procedure for providing information about the risks associated with meningococcal disease and hepatitis B and the availability and effectiveness of any vaccine against meningococcal disease and hepatitis B.

(1986, c. 621; 1987, c. 366; 1990, c. 273; 2001, c. 340; 2005, c. 15.)

Section A ***Medical History***

Name: _____ ***Date of Birth:*** _____

Have you had or are now experiencing any of the following? If yes, note the date of occurrence if known:

	Yes	No	Date
Head/ Neurological			
Frequent headaches/migraines	○	○	_____
Dizziness or fainting	○	○	_____
Loss of consciousness	○	○	_____
Head injuries	○	○	_____
Neck/spine/back injury	○	○	_____
Eyes/ Ears/ Nose/ Throat			
Vision or eye problems	○	○	_____
Tonsil/Adenoid removal	○	○	_____
Allergies or hay fever	○	○	_____
Ear or hearing problems	○	○	_____
Sinusitis/ Strep	○	○	_____
Dental problems or TMJ	○	○	_____
Skin			
Severe acne or skin disorder	○	○	_____
New or changing moles	○	○	_____
Blood Disorder			
Anemia/Sickle Cell	○	○	_____
Bleeding disorder	○	○	_____
Enlarged glands /lymph nodes	○	○	_____
Heart/ Circulation/ Chest			
Severe chest pain or pressure	○	○	_____
Heart disease or murmur	○	○	_____
Rapid irregular pulse	○	○	_____
Myocarditis	○	○	_____
Mononucleosis	○	○	_____
Blood Clots or vein problems	○	○	_____
Family member with heart attack Or death before age 50	○	○	_____
Respiratory			
Chronic cough (over 1 month)	○	○	_____
Pneumonia	○	○	_____
Tuberculosis or positive PPD	○	○	_____
Shortness of breath	○	○	_____
Wheezing	○	○	_____
Tobacco Use:	○	○	_____
Chew tobacco	○	○	_____
Smoke	○	○	_____

	Yes	No	Date
Gastrointestinal			
Abdominal Pain (severe/recurrent)	○	○	_____
Ulcer	○	○	_____
Constipation	○	○	_____
Blood in stool	○	○	_____
Hepatitis A,B,C	○	○	_____
Hernia	○	○	_____
Musculoskeletal			
Swollen or painful joints or extremities	○	○	_____
Chronic or severe back problems	○	○	_____
Lumps in armpit or groin	○	○	_____
Chronic Diseases			
Diabetes mellitus	○	○	_____
Asthma	○	○	_____
High Blood Pressure	○	○	_____
Arthritis	○	○	_____
Sickle cell disease	○	○	_____
Seizures or epilepsy	○	○	_____
Thyroid disease	○	○	_____
Elevated Cholesterol	○	○	_____
Genitourinary			
Urinary or kidney problems	○	○	_____
Additional medical history			
Cancer	○	○	_____
Unusual fatigue (over 1 month)	○	○	_____
Recent gain or loss of weight (over 10 pounds)	○	○	_____
Eating disorder	○	○	_____
Female			
Absent or irregular periods	○	○	_____
Disabling cramps w/ period	○	○	_____
Diet			
Special diet for medical reasons	○	○	_____
Mental Health			
OCD	○	○	_____
Depression	○	○	_____
Schizophrenia	○	○	_____
Bipolar	○	○	_____
Asperger's Syndrome	○	○	_____
ADHD or ADD	○	○	_____

Other:

_____

_____

_____

_____

HEALTH FORM

Section B

PHYSICAL EXAMINATION

Name: _____ ***Date:*** _____

****REQUIRED FOR ALL RESIDENT AND FULL TIME STUDENTS / RECOMMENDED FOR ALL STUDENTS****
ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED BY A PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

Vital Signs

*Pulse*_____ *Blood Pressure*_____ *Height*_____ *Weight*_____

Vision Screening:

*Right 20/*_____ *Corrected to 20/*_____ *Left 20/*_____ *Corrected to 20/*_____

Laboratory (if indicated): ***According to NCAA guidelines, all student athletes must have Sickle Cell and Trait testing done prior to participation in sports activities.***

Results	*Results*	*Results*
*CBC*_____	*Urinalysis*_____	*Other*_____
*Serology*_____	***Sickle Cell - Date:*** _____ *Results:* _____	*Other*_____

SYSTEMS	***FINDINGS***
General Appearance	
HEENT	
Cardiovascular	
Lungs	
Breast	
Abdomen	
Genitalia	
Musculoskeletal	
Spine	
Skin & Lymphatic	
Neurological	

SUMMARY OR ASSESSMENT AND DIAGNOSIS:

_____

RECOMMENDATIONS:

_____

_____

TYPED OR PRINTED NAME OF PROVIDER *SIGNATURE* *DATE*

Section C ***Required Immunizations**

TO BE COMPLETED BY MEDICAL PERSONNEL OR ATTACH A COPY OF SHOT RECORD

*Name*_____ ***Date of Birth***_____

A. Measles, Mumps and Rubella: Individuals born before 1957 are considered immune.

Date of Birth:	
MMR#1	Date:
MMR#2	Date:
□Titer indicating immunity: (attach a copy)	Date: Level/Value:

B. Tetanus Diphtheria or Tdap *Last booster must be within the past 10 years

TD, DT:	Date:
TDap	Date:

C. Polio (OPV or IPV):

Completion of primary series in childhood	□Yes □No
Last booster	Date:

D. PPD / Tuberculosis test

Date of TB Screening:	Is TB test recommended? □Yes □No
Date of test:	Results: □ Negative □ Positive (size) _____ mm
Chest X-Ray Results: □ Negative □ Positive	Treatment /Medication recommended? □Yes □No
Medication Prescribed:	Duration:

E. Hepatitis B or Waiver

Hepatitis B #1	Date:
Hepatitis B #2	Date:
Hepatitis B #3	Date:
□ Titer indicating immunity: (attach a copy)	Date: Level/ Value:
□ Signed Hepatitis B Waiver	Date:

F. Meningococcal Vaccine or Waiver

Meningococcal Vaccination	Date:
Menactra Vaccination	Date:
□ Signed Meningitis waiver	Date:

G. Varicella Vaccine (chicken pox)

Has had disease as child? □Yes □No	
Varicella Dose# 1	Date:
Varicella Dose # 2	Date:
Titer indicating immunity (attach a copy)	Date: Level/Value:

Provider (printed) Name & Title Provider Signature	Address or Office Stamp and Phone Number:

Spartan Health Center

MENINGOCOCCAL and Hepatitis B VACCINE WAIVER

I have read the information provided about meningococcal meningitis and Hepatitis B and understand the risks of the disease; however, I choose not to receive the vaccine. I understand that in the event of an outbreak, unvaccinated students will be at increased risk for contracting the illness. Information can be found on the following website: http://www.cdc.gov/vaccines/vpd-vac/default.htm

Student's Printed Name: _____ Birth Date: _____

Student Signature_____ Date:_____

As a parent or other legal representative, I choose **not** to have the student named above vaccinated against □ Meningococcal and □ Hepatitis B disease.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

NORFOLK STATE UNIVERSITY®

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