NORFOLK STATE UNIVERSITY
Health History and Physical Form (Sections I - IV)

Virginia State Law (Code 23-7.5) requires all students to submit a completed Health History and Immunization record. Sections I, II and IV of this form are required by law; however, section III is optional (highly recommended).

CONFIDENTIAL

Section I - Required

Name _____ Sex ____ Age _____
Last First Middle

Classification _____ Major _____ ☐On-Campus ☐Off-Campus

Home Address _____
Street City State Zip

Local Address _____
Street City State Zip

Birthdate _____ Soc Sec# _____ Local telephone #(___) _____

Emergency Contact _____ (___) _____
Name Relationship

Family Physician _____ (___) _____
Name

Insurance Information _____
Name of Insured Insurance Company Policy #

I certify that the above information is correct. I give permission to Norfolk State University or its representative(s) to: 1) Secure healthcare services which may include transportation to a health care provider and/or to a hospital in case of a serious or emergent illness or injury, physical examination, injection(s) treatment(s) and diagnostics; and 2) To release health information to persons who have legitimate need to know as defined by state and federal regulations.

Student Signature _____ Date _____

_____ Date _____
Signature of Parent/Legal Guardian for Student under age 18

Allergies

List all Type of reaction

Food(s) _____
Medications _____
Other _____

Current Medications

Name Dosage Frequency (include over-the-counter & Herbal)

_____
_____
_____

Hospitalization/Surgery

Year Reason

_____
_____
_____

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:

_____

_____

_____

_____

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 <u>not</u> 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: _____