NORFOLK STATE UNIVERSITY

Health History and Physical Form

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

Return forms via mail to: Spartan Health Center
700 Park Ave, Rm 101
Norfolk, VA 23504
757-823-2695 (fax)

HEALTH APPLICATION

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	○	○	_____
Genitourinary			
Urinary or kidney problems	○	○	_____

	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	○	○	_____
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:

_____

_____

_____

_____

PHYSICAL EXAMINATION

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

*****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 Trait testing done prior to participation in sports activities or sign a waiver.

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	

ASSESSMENT AND DIAGNOSIS:

_____

RECOMMENDATIONS:

_____

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

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.

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:	**☐ Negative ☐ Positive(size) _____mm**
Chest X-Ray Results: ☐ Negative ☐ Positive	**Treatment/Medication recommended? ☐ Yes ☐ No**
Medication Prescribed:	

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

Meningitis Vaccine #1:	**Date:**
Meningitis Vaccine #2:	**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 above named student vaccinated against

☐ Meningococcal ☐ Hepatitis B disease

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____