University of the Virgin Islands

Student Health Form

PHYSICAL EXAMINATION

(To be completed by medical provider)

HEALTH FORM MUST BE COMPLETED AND RETURNED TO THE UNVERSITY'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

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH (mo / day / year)	SEX

RESIDENTIAL ADDRESS	STREET RURAL ROUTE	CITY	ISLAND / STATE

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	ZIP CODE

PARENT OR GUARDIAN NAME	HOME PHONE	BUSINESS PHONE

PARENT OR GUARDIAN RESIDENTIAL ADDRESS (IF DIFFERENT FROM ABOVE)	STUDENT E-MAIL ADDRESS

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

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 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

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Last Name_____First Name_____Initial_____Sex_____ DOB _____

Mailing Address _____ Phone _____ (H W C)

City _____ State _____ Zip Code _____ University ID# _____

Employer_____ Occupation _____ Work Phone_____

Emergency Contact Information

Name_____ Relationship_____ Phone _____

Address_____ City_____ State _____ Zip_____

Patient Medical History Information

YES	NO	DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO	DO YOU HAVE OR HAVE YOU EVER HAD:	COMMENTS (Office Use Only)
		1. Eye trouble (***exclude*** *glasses, contact lenses)*			31. Frequent or painful urination	
		2. **ANY** allergies:			32. Blood, protein, or sugar in urine	
		3. Take any medications regularly			33. History of diabetes	
		4. Frequent, severe, or migraine headaches			34. Kidney stone	
		5. Fainting or dizzy spells			35. Hernia or rupture	
		6. Periods of unconsciousness			36. Back pain or trouble	
		7. Head injury or skull fracture			37. Paralysis or weakness	
		8. Epilepsy, seizures or convulsions			38. Foot trouble / use orthotics	
		9. Loss of memory *(amnesia)*			39. Rheumatic fever	
		10. Depression, anxiety or nervousness			40. Any bone or joint problem or injuries	
		11. Any mental condition or illness			41. Tuberculosis or positive TB test	
		12. Hearing loss			42. Sexually transmitted disease *(STD)*	
		13. Ear, nose, or throat trouble			43. Any skin conditions	
		14. Sinusitis or sinus trouble			44. Adverse reactions to vaccines / drugs	
		15. Hay fever or allergic rhinitis			45. Adverse reactions to food / insect bites	
		16. Tooth/gum trouble or current orthodontics			46. Sensitivity to chemical, dust, sunlight, etc.	
		17. Thyroid trouble			47. Eating disorder	
		18. Chronic cough or lung disease			48. Recent gain or loss of weight	
		19. Asthma or wheezing			49. Excessive bleeding or easy bruising	
		20. Unusual shortness of breath			50. Tumor, growth, cyst, or cancer	
		21. Pain or pressure in chest			51. Considered or attempted suicide	
		22. Palpation or pounding heart			52. Learning disability or speech problems	
		23. High blood pressure			53. Had **ANY** surgery	
		24. Heart trouble or heart murmur			54. Any other injury or illness not noted above	
		25. Stomach, liver, or intestinal problem	XXXX	XXXX	**FEMALES ONLY**	
		26. Gallbladder trouble or gallstones			55. Had a change in menstrual pattern	
		27. Hepatitis *(yellow jaundice)*			56. Been treated for a female disorder	
		28. Hemorrhoids or rectal disease			57. Experience painful periods or cramps	
		29. Black or bloody stools			58. Have you ever been pregnant	
		30. Constipation / Diarrhea			59. Are you currently pregnant	

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)

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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:** _____

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

CURRENT MEDICATIONS:

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

CURRENT TREATMENT(S):

SURGICAL & PAST MEDICAL HISTORY:

ADDENDUM:

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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)

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Name: _____ **Date of Birth**: _____ **Gender**: **M / F**

Date: _____ **Time: _____** **Student Status:** ☐ **FT** ☐ **PT**

TUBERCULOSIS (TB) SCREENING/TESTING[1]

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? ❑ Yes ❑ No
(If yes, please CIRCLE the country, below)

Afghanistan	Côte d'Ivoire	Kenya	Nicaragua	South Africa
Algeria	Democratic People's Republic of Korea	Kiribati	Niger	South Sudan
Angola		Kuwait	Nigeria	Sri Lanka
Argentina	Democratic Republic of the Congo	Kyrgyzstan	Niue	Sudan
Armenia		Lao People's Democratic Republic	Pakistan	Suriname
Azerbaijan	Djibouti		Palau	Swaziland
Bahrain	Dominican Republic	Latvia	Panama	Tajikistan
Bangladesh	Ecuador	Lesotho	Papua New Guinea	Thailand
Belarus	El Salvador	Liberia	Paraguay	Timor-Leste
Belize	Equatorial Guinea	Libya	Peru	Togo
Benin	Eritrea	Lithuania	Philippines	Trinidad and Tobago
Bhutan	Estonia	Madagascar	Poland	Tunisia
Bolivia (Plurinational State of)	Ethiopia	Malawi	Portugal	Turkey
Bosnia and Herzegovina	Fiji	Malaysia	Qatar	Turkmenistan
Botswana	Gabon	Maldives	Republic of Korea	Tuvalu
Brazil	Gambia	Mali	Republic of Moldova	Uganda
Brunei Darussalam	Georgia	Marshall Islands	Romania	Ukraine
Bulgaria	Ghana	Mauritania	Russian Federation	United Republic of Tanzania
Burkina Faso	Guatemala	Mauritius	Rwanda	
Burundi	Guinea	Mexico	Saint Vincent and the Grenadines	Uruguay
Cabo Verde	Guinea-Bissau	Micronesia (Federated States of)		Uzbekistan
Cambodia	Guyana		Sao Tome and Principe	Vanuatu
Cameroon	Haiti	Mongolia	Senegal	Venezuela (Bolivarian Republic of)
Central African Republic	Honduras	Morocco	Serbia	
Chad	India	Mozambique	Seychelles	Viet Nam
China	Indonesia	Myanmar	Sierra Leone	Yemen
Colombia	Iran (Islamic Republic of)	Namibia	Singapore	Zambia
Comoros	Iraq	Nauru	Solomon Islands	Zimbabwe
Congo	Kazakhstan	Nepal	Somalia	

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.

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)

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

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.

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

[1]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.