Revised May 2007

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.

MAIL TO 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

SIGNATURE OF STUDENT (IF OVER 18 YEARS OLD)

PLEASE PRINT CLEARLY

SIGNATURE

DATE (mo / day / year)

Revised July 2014
University of the Virgin Islands – Student Health Form

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

<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>1.</td>
<td></td>
<td>Eye trouble (exclude glasses, contact lenses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>YES</td>
<td>ANY allergies:</td>
<td></td>
<td></td>
<td>31.</td>
<td>Frequent or painful urination</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>Take any medications regularly</td>
<td></td>
<td></td>
<td>32.</td>
<td>Blood, protein, or sugar in urine</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>Frequent, severe, or migraine headaches</td>
<td></td>
<td></td>
<td>33.</td>
<td>History of diabetes</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>Fainting or dizzy spells</td>
<td></td>
<td></td>
<td>34.</td>
<td>Kidney stone</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td>Periods of unconsciousness</td>
<td></td>
<td></td>
<td>35.</td>
<td>Hernia or rupture</td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td>Head injury or skull fracture</td>
<td></td>
<td></td>
<td>36.</td>
<td>Back pain or trouble</td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td>Epilepsy, seizures or convulsions</td>
<td></td>
<td></td>
<td>37.</td>
<td>Paralysis or weakness</td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td>Loss of memory (amnesia)</td>
<td></td>
<td></td>
<td>38.</td>
<td>Foot trouble / use orthotics</td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td>Depression, anxiety or nervousness</td>
<td></td>
<td></td>
<td>39.</td>
<td>Rheumatic fever</td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td>Any mental condition or illness</td>
<td></td>
<td></td>
<td>40.</td>
<td>Any bone or joint problem or injuries</td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td>Hearing loss</td>
<td></td>
<td></td>
<td>41.</td>
<td>Tuberculosis or positive TB test</td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td>Ear, nose, or throat trouble</td>
<td></td>
<td></td>
<td>42.</td>
<td>Sexually transmitted disease (STD)</td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td>Sinusitis or sinus trouble</td>
<td></td>
<td></td>
<td>43.</td>
<td>Any skin conditions</td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td>Hay fever or allergic rhinitis</td>
<td></td>
<td></td>
<td>44.</td>
<td>Adverse reactions to vaccines / drugs</td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td>Tooth/gum trouble or current orthodontics</td>
<td></td>
<td></td>
<td>45.</td>
<td>Adverse reactions to food / insect bites</td>
</tr>
<tr>
<td>17.</td>
<td></td>
<td>Thyroid trouble</td>
<td></td>
<td></td>
<td>46.</td>
<td>Sensitivity to chemical, dust, sunlight, etc.</td>
</tr>
<tr>
<td>18.</td>
<td></td>
<td>Chronic cough or lung disease</td>
<td></td>
<td></td>
<td>47.</td>
<td>Eating disorder</td>
</tr>
<tr>
<td>19.</td>
<td></td>
<td>Asthma or wheezing</td>
<td></td>
<td></td>
<td>48.</td>
<td>Recent gain or loss of weight</td>
</tr>
<tr>
<td>20.</td>
<td></td>
<td>Unusual shortness of breath</td>
<td></td>
<td></td>
<td>49.</td>
<td>Excessive bleeding or easy bruising</td>
</tr>
<tr>
<td>21.</td>
<td></td>
<td>Pain or pressure in chest</td>
<td></td>
<td></td>
<td>50.</td>
<td>Tumor, growth, cyst, or cancer</td>
</tr>
<tr>
<td>22.</td>
<td></td>
<td>Palpation or pounding heart</td>
<td></td>
<td></td>
<td>51.</td>
<td>Considered or attempted suicide</td>
</tr>
<tr>
<td>23.</td>
<td></td>
<td>High blood pressure</td>
<td></td>
<td></td>
<td>52.</td>
<td>Learning disability or speech problems</td>
</tr>
<tr>
<td>24.</td>
<td></td>
<td>Heart trouble or heart murmur</td>
<td></td>
<td></td>
<td>53.</td>
<td>Had ANY surgery</td>
</tr>
<tr>
<td>25.</td>
<td></td>
<td>Stomach, liver, or intestinal problem XXXX</td>
<td></td>
<td></td>
<td>54.</td>
<td>Any other injury or illness not noted above</td>
</tr>
<tr>
<td>26.</td>
<td></td>
<td>Gallbladder trouble or gallstones XXXX</td>
<td></td>
<td></td>
<td>55.</td>
<td>Had a change in menstrual pattern</td>
</tr>
<tr>
<td>27.</td>
<td></td>
<td>Hepatitis (yellow jaundice)</td>
<td></td>
<td></td>
<td>56.</td>
<td>Been treated for a female disorder</td>
</tr>
<tr>
<td>28.</td>
<td></td>
<td>Hemorrhoids or rectal disease</td>
<td></td>
<td></td>
<td>57.</td>
<td>Experience painful periods or cramps</td>
</tr>
<tr>
<td>29.</td>
<td></td>
<td>Black or bloody stools</td>
<td></td>
<td></td>
<td>58.</td>
<td>Have you ever been pregnant</td>
</tr>
<tr>
<td>30.</td>
<td></td>
<td>Constipation / Diarrhea</td>
<td></td>
<td></td>
<td>59.</td>
<td>Are you currently pregnant</td>
</tr>
</tbody>
</table>

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>
</tr>
</thead>
<tbody>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEART</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LUNGS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABDOMEN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXTREMITIES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEURO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SKIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENITAL (General PE Only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CURRENT MEDICATIONS:

<table>
<thead>
<tr>
<th>Name of Medication(s)</th>
<th>Dosage</th>
<th>How Often</th>
<th>Discontinued</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CURRENT TREATMENT(S):

__________________________________________________________________________________

SURGICAL & PAST MEDICAL HISTORY:

__________________________________________________________________________________

__________________________________________________________________________________

ADDENDUM:

__________________________________________________________________________________
**IMMUNIZATIONS: Required for all students**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Requirement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio</td>
<td><em><strong>/</strong></em> <em><strong>/</strong></em> <em><strong>/</strong></em> (3 doses are acceptable)</td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td><em><strong>/</strong></em></td>
<td>(Get a Tdap Vaccine once then TD booster every 10 years)</td>
</tr>
<tr>
<td>TD</td>
<td><em><strong>/</strong></em> <em><strong>/</strong></em> <em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td><em><strong>/</strong></em> <em><strong>/</strong></em> <em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td><em><strong>/</strong></em> <em><strong>/</strong></em> <em><strong>/</strong></em> <em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td><em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>(A history of chicken pox, a positive varicella antibody or 2 doses of vaccines meet the requirement)</td>
<td>Dose #1 <em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td></td>
<td>Dose #2 <em><strong>/</strong></em>/___</td>
<td>1. ☐ History of Disease 2. Varicella antibody</td>
</tr>
<tr>
<td>PPD or TST (Tuberculin Skin Test)</td>
<td><em><strong>/</strong></em>/___</td>
<td>PPD Reading: <em><strong>/</strong></em>/___ mm ☐ Negative ☐ Positive</td>
</tr>
<tr>
<td>PPD or TST (Tuberculin Skin Test)</td>
<td><em><strong>/</strong></em>/___</td>
<td>PPD Reading: <em><strong>/</strong></em>/___ mm ☐ Negative ☐ Positive</td>
</tr>
<tr>
<td>CXR Results (required for positive PPD)</td>
<td>_________</td>
<td>☐ INH Treatment Received: ____ 3 months ____ 6 months ____ 9 months</td>
</tr>
</tbody>
</table>

**LABORATORY TEST RESULTS:**

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC</td>
<td>_______</td>
</tr>
<tr>
<td>UA</td>
<td>_______</td>
</tr>
<tr>
<td>FBS</td>
<td>_______</td>
</tr>
</tbody>
</table>

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) 692-4225 (Fax)

St. Thomas Campus
Health Service Center
#2 John Brewers Bay
St. Thomas, VI 00802-9990
(340) 693-1211 (Fax)
Name: __________________________________________ Date of Birth: ________ Gender: M / F
Date: ____________________ Time: ________ Student Status: □ FT □ PT

TUBERCULOSIS (TB) SCREENING/TESTING¹

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

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.

1The 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.