University of the Virgin Islands

STUDENT HEALTH FORM

(Physical Examination section to be completed by a medical provider)

FORM MUST BE COMPLETED AND UPLOADED TO THE MEDICAT PORTAL (https://uvi.medicatconnect.com) PRIOR TO MOVING ON CAMPUS OR REGISTERING FOR CLASSES

Contact Information: Health Services Center

Albert A. Sheen Campus (St. Croix)
RR#1 Box 10, 000 Kingshill
St. Croix, VI 00850-9781
(340) 692-4208 (Office)

Orville E. Kean Campus (St. Thomas)
#2 John Brewers Bay
St. Thomas, VI 00802-9990
(340) 693-1124 (Office)

INSTRUCTIONS:

1. Visit the Medicat portal **(https://uvi.medicatconnect.com)** and complete the
   a. UVI Health History form
   b. Texting Opt-in-Opt-Out form
   c. Enter the immunization dates on immunization tab
   d. Upload all health records including your physical exam, PPD (tuberculin skin test), and proof of vaccinations.
2. If you are under 18 years of age, a parent or guardian MUST complete and sign the Medical Consent Section of this Student Health Form.
3. Have a licensed medical provider (NP, MD, DO, or PA) fill out the physical examination section of this form including the required laboratory tests results.

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) to provide medical 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 understand 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, 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)

DATE
(mo / day / year)

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PHYSICAL EXAMINATION SECTION

Student Name _____ **DOB** _____/_____/_____ **Female** ____ **Male**

Height _____ **Weight** _____lbs **BMI**_____ **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 PR Only)				

CURRENT MEDICATIONS:

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

CURRENT MEDICAL CONDITION(S) AND TREATMENT(S):

_____

_____

SURGICAL & PAST MEDICAL HISTORY:

_____

_____

ADDENDUM:

_____

_____

IMMUNIZATIONS: Required for all students

Please upload proof of all below vaccines, lab, and PPD test results to the Medicat Portal on the upload tab

Polio: ____/____/_____/____/_____/____/____ (3 doses acceptable)

Tetanus, Diphtheria, Pertussis: Primary series completed? Yes_____No _____ Date of last dose in series: ____/____/____

Date of most recent booster dose: ____/____/____ **Type of booster:** Td_____Tdap _____

MMR: ____/____/_____/____/____

Hepatitis B: ____/____/_____/____/_____

Meningococcal Quadrivalent (ACYW-135): __/__/__

****If MEN ACYW is received before the age of 16, you will need an additional vaccine for residential living __/__/____**

Covid Vaccine(ONLY if requesting residential living on campus): Name: _____ Doses:___/____/____

/___/___/___ **Booster:** ____/___/____(Not required for residential living)

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: Year _____or age _____

2. Varicella antibody Date __/___/__ Result Reactive _____non-Reactive_____

PPD Skin Test is required for ALL students every 2 years. (Yearly for Nursing students in Clinicals).

PPD or TST (Tuberculin Skin Test) ____/____/____ PPD Reading: ____/____/_____ mm Negative Positive

CXR Results (required for positive PPD): _____ INH Treatment rec'd _____3 mons _____6 mons _____9 mons

LABORATORY TEST RESULTS: CBC: _____UA: _____FBS: _____ Lab Slip Given

According to my review of systems, history, and physical examination of the student:

_____She/He/They are fit for any form of physical

_____She/He/They should be excused from participation in strenuous physical activity

_____She/He/They 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)

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