HAMPTON UNIVERSITY 55 EAST TYLER STREET HAMPTON, VIRGINIA 23668

Health Services PLEASE PRINT OR TYPE						
PERSONAL	Date:					
Name						
Address	First	Middle Initial				
Number Street		ty State	Zip Code			
Telephone Number ()	Social Security Number_		_ Date of Birth			
Name and relationship of emergency cor	ntact					
Name						
Last	First	Middle Initial				
Relationship	Telephone N	Area Code				
PARENT MEDICAL CONSENT						
I give my consent for						
emergency treatment is required and I am a official (i.e., Health Center, Dean of Men,						
hospitalization. I understand that such treat		inalis, etc.) to approve of	r necessary treatment and/o			
-		_				
Signature	-dian(s)	Date				
The following questions are designed to pr	otect YOUR HEALTH.					
Personal History (<i>Check all that apply</i>)						
A. Have you ever had (or have now):						
Dizziness	☐ Fits or seizures	□ Racing of heart or	palpitations			
Severe headaches	□ Chest Pain	☐ Asthma				
Black-outs or near black-outs	□ Wheezing or coughing	□				
B. List any frequently taken medicines (pr	escribed or over the counter):					
C. Do you have any food or medication all	lergies? If so, please explain.					
Past History (Check all that apply) Have y	you ever been told of having or advise	ed of any of the following	g:			
☐ Heart murmur(s)	☐ Sickle cell "trait" or anemia	\Box Heat exhaustion of	r "stroke" or cramps			
□ High blood pressure	□ Severe "sprains"	☐ Fractures				
□ Heart failure	🗌 Marfan's Syndrome	Severe ligament in	ijuries			
☐ Kidney disease or "trouble"		□ Other lung disease	;			
\Box Protein or blood in the urine	□ Other head injuries	□				
□ Other heart disease	□ Asthma					
Family History (Check all that apply) Ha	s any parent, grandparent, sister or br	other had any of the follo	owing:			
Died before age 50 (<i>cause if known</i>)	Heart attack	☐ Heart "failure"				
	Sickle cell "trait" or anemia	□ Marfans syndrome				
	\Box Distances " ~ 2	-				
High blood pressure	Diabetes or "sugar"					

PHYSICAL EXAMINATION *MUST BE COMPLETED ON UNIVERSITY FORM ONLY*

(TO BE COMPLETED BY EXAMINER)

-	Blood Pressure Pulse		
Normal	Check in appropriate column. (Enter NE if not evaluated)	Abnormal	Notes: Describe abnormality. (Enter item number before each comment.)
	1. Head, face, neck and scalp.		
	2. Nose		
	3. Mouth and throat		
	4. Ears – general		
	5. Eyes – general		
	6. Chest – general		
	7. Lungs		
	8. Breasts		
	9. Cardiovascular System		
	10. Abdomen (include hernias)		
	11. Genitalia		
	12. Upper extremities		
	13. Lower extremities		
	14. Spine		
	15. Skin and lymphatics		
	rks and pertinent history related to P.E. findings hary of defects and diagnosis (Place supporting it	em numbers by	diagnosis)
18. Recon	nmendations – Further specialist examinations in	dicated (specify)
19. Exam	inee (check one)		

[] is qualified for athletic participation

[] is not qualified for athletic participation

Typed or printed name of reviewing physician

Signature (examiner) (MD, DO, NP, PA)

IMMUNIZATION RECORD

*Immunity is <u>required</u> prior to registration. Please complete and return this form.

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER (Dates must include month and year.) *A. TETANUS-DIPTHERIA (<i>Required</i>) 1 Completed primary series of tetanus-diptheria immunizations 2. Received tetanus-diptheria booster (required every 10 years) 3. Tdap (preferred)) to replace single dose of Td for booster immunization with at least five years since last dose of Td *B. M.M.R. (Measles, Mumps, Rubella) (<i>Required</i>)	NAME	,		 <i>M. I.</i>		
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MONTH DATE YEAR			DATE	YEAR		
MONTH DATE YEAR		MONTH	DATE	YEAR		
		MONTH	DATE	YEAR		

HEALTH CARE PROVIDER

Name	Address
Signature	Phone ()