HAMPTON UNIVERSITY
55 EAST TYLER STREET
HAMPTON, VIRGINIA 23668

Application for Summer Program Participation

Health Services

PLEASE PRINT OR TYPE

PERSONAL

Date:_____

Name _____
Last *First* *Middle Initial*

Address _____
Number *Street* *City* *State* *Zip Code*

Telephone Number (_____) _____ Social Security Number _____ Date of Birth _____
Area Code

Name and relationship of emergency contact

Name _____
Last *First* *Middle Initial*

Relationship _____ Telephone Number (_____) _____
Area Code

PARENT MEDICAL CONSENT

I give my consent for _____ to receive the medical care available to Summer Program students. In the event that emergency treatment is required and I am not available, I give my consent for the program director, their representative or other HU official (i.e., Health Center, Dean of Men, Dean of Women, V.P. for Student Affairs, etc.) to approve of necessary treatment and/or hospitalization. I understand that such treatment will be at my expense.

Signature _____ Date _____
Parent(s)/Guardian(s)

The following questions are designed to protect YOUR HEALTH.

Personal History *(Check all that apply)*

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 (prescribed or over the counter):

_____ _____

C. Do you have any food or medication allergies? If so, please explain. _____

_____

Past History *(Check all that apply)* Have you ever been told of having or advised of any of the following:

☐ Heart murmur(s) ☐ Sickle cell "trait" or anemia ☐ Heat exhaustion or "stroke" or cramps
☐ High blood pressure ☐ Severe "sprains" ☐ Fractures
☐ Heart failure ☐ Marfan's Syndrome ☐ Severe ligament injuries
☐ Kidney disease or "trouble" ☐ Concussion ☐ Other lung disease
☐ Protein or blood in the urine ☐ Other head injuries ☐ _____
☐ Other heart disease ☐ Asthma

Family History *(Check all that apply)* Has any parent, grandparent, sister or brother had any of the following:

☐ Died before age 50 *(cause if known)* ☐ Heart attack ☐ Heart "failure"
_____ ☐ Sickle cell "trait" or anemia ☐ Marfans syndrome
☐ High blood pressure ☐ Diabetes or "sugar"

Signature _____
Participant/Guardian

PHYSICAL EXAMINATION

MUST BE COMPLETED ON UNIVERSITY FORM ONLY

(TO BE COMPLETED BY EXAMINER)

Height _____ Blood Pressure _____ Urinalysis: Albumin _____

Weight _____ Pulse _____ Sugar _____

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		

16. Remarks and pertinent history related to P.E. findings

17. Summary of defects and diagnosis (Place supporting item numbers by diagnosis)

18. Recommendations – Further specialist examinations indicated (specify)

19. Examinee *(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)	Date

IMMUNIZATION RECORD

Immunity is required prior to registration. Please complete and return this form.

NAME _____ (LAST) _____ (FIRST) _____ (M. I.)

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER (Dates must include month and year.)

A. TETANUS-DIPTHERIA *(Required)

1. ☐ Completed primary series of tetanus-diptheria immunizations ..... MONTH DATE YEAR
2. ☐ Received tetanus-diptheria booster (required every 10 years) ..... MONTH DATE YEAR
3. ☐ Tdap (preferred) to replace single dose of Td for booster immunization with at least five years since last dose of Td ..... MONTH DATE YEAR

B. M.M.R. (Measles, Mumps, Rubella) *(Required)

1. ☐ Dose 1 – Immunization date required at exactly 12 months or after and before 5 years ..... MONTH DATE YEAR
2. ☐ Dose 2 – Immunized at 5 years or later ..... MONTH DATE YEAR

***C. MEASLES (Rubeola) – if given instead of MMR. Check appropriate box.**

1. ☐ Has report of immune titer. **Specify date and send copy of positive results.** ..... MONTH DATE YEAR
2. ☐ Immunized with live measles vaccine at 12 months after birth or later. ..... MONTH DATE YEAR

***D. RUBELLA – if given instead of MMR. Check appropriate box.**

1. ☐ Has report of immune titer. **Specify date and send copy of positive results.** ..... MONTH DATE YEAR
2. ☐ Immunized with vaccine at 12 months after birth or later. ..... MONTH DATE YEAR

***E. MUMPS – if given instead of MMR. Check appropriate box.**

1. ☐ Has report of immune titer. **Specify date and send copy of positive results.** ..... MONTH DATE YEAR
2. ☐ Immunized with vaccine at 12 months after birth or later. ..... MONTH DATE YEAR

F. TUBERCULOSIS – Interpretation based on mm of induration. *Check appropriate box.*

***(Required of International Students Only)**

1. ☐ PPD (Mantoux) test within the past year (Tine or monovac not acceptable)
   Give date placed ..... Date MONTH DATE YEAR — Result: ☐ Positive ☐ Negative
   Give date read and results (based on millimeters) ..... Date MONTH DATE YEAR — _____ mm
2. ☐ Positive PPD – Chest x-ray required.
   Give date and result of chest x-ray ..... Date MONTH DATE YEAR — Result: ☐ Positive ☐ Negative
3. ☐ Had BCG vaccine – Chest x-ray required if PPD not done ..... Date MONTH DATE YEAR

G. POLIO *(Required)

1. ☐ Completed primary series of polio immunization ..... ☐ Yes ☐ No MONTH DATE YEAR
   Type of vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV
   Last booster ..... MONTH DATE YEAR

H. MENINGOCOCCAL MENINGITIS *(Required)

1. ☐ MENOMUNE - **Immunization and updates as per CDC guidelines.** ..... MONTH DATE YEAR
2. ☐ Menactra - (Conjugate) **Immunization and updates as per CDC guidelines.** ..... MONTH DATE YEAR

I. ☐ HEPATITIS B VACCINE SERIES *(RECOMMENDED OR WAIVER)* ..... MONTH DATE YEAR

***(Required for Health Care Profession Students)**

MONTH DATE YEAR

MONTH DATE YEAR

HEALTH CARE PROVIDER

Name _____ Address _____

Signature _____ Phone (____) _____

HC (Revised 03/15)