

Hampton University Student Health Center

132 William R. Harvey Way • Hampton, Virginia 23668 • Phone 757-727-5315

SPECIAL PROGRAM HEALTH HISTORY FORM

PRINT CLEARLY WITH DARK BLACK INK.

Please clearly complete ALL required sections. Red asterisks (*) indicated required sections.
This form will be reviewed by the Health Center for final determination of medical clearance.

Program Information

*Name of Special Program: _____

*Start Date of Special Program: _____

Student Information

*Participant Name: _____

Last Name

First Name

Middle Initial

*Address: _____

Number

Street

City

State

Zip Code

*Telephone Number: _____

*Date of Birth: _____

*HUID # (if applicable): _____

Emergency Contact Information

*Emergency Contact Name: _____

Last Name

First Name

Middle Initial

*Relationship: _____

*Telephone Number (including Area Code): _____

PARENTAL/GUARDIAN MEDICAL TREATMENT CONSENT FOR MINORS

This section is required for all participants under 18 years of age.

I give consent for my child to receive the medical care available to Special Program participants. 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 Hampton University official (i.e., Health Center, Vice President for Student Success and Enrollment Management, Dean of Students, etc.) to approve of necessary treatment and/or hospitalization. I understand that such treatment will be at my expense.

PARENT/GUARDIAN (All Sections Required)

*Print Parent(s)/Guardian(s) First and Last Name

*Parent(s)/Guardian(s) First and Last Name Signature

*Signature Date

Health History Information

A. PERSONAL HISTORY – CHECK ALL THAT APPLY.

1. Has the student/participant ever had (or have now):

Dizziness

Severe headaches

Fainting or near fainting

Other, not listed. Please explain: _____

Seizures

Chest pain

Wheezing or coughing

Racing of heart or palpitations

Asthma

Depression/Anxiety

2. List any frequently taken medicines (prescribed or over the counter): _____

3. Does the student/participant have any food or medication allergies? If so, please explain. _____

4. Has the student/participant been advised and instructed on the proper use of their Epi Pen? Yes No N/A

B. PAST HISTORY – CHECK ALL THAT APPLY.

1. Has the student/participant ever been told of having or advised of any of the following:

Heart murmur(s)

High blood pressure

Heart failure

Kidney disease

Protein of blood in the urine

Other heart disease

Sickle cell trait or anemia

Severe sprains

Marfan's Syndrome

Concussion

Other head injuries

Asthma

Heat exhaustion

Fractures

Severe ligament injuries

Other lung disease

Other, not listed. Please explain: _____

C. FAMILY HISTORY – CHECK ALL THAT APPLY.

1. Has any parent, grandparent, sister or brother had any of the following:

Died before age 0 (cause if known) _____

High blood pressure

Heart attack

Sickle cell trait or anemia

Diabetes

Heart failure

Marfan's Syndrome

PARENT/GUARDIAN (All Sections Required)

*Print Parent(s)/Guardian(s) First and Last Name

*Parent(s)/Guardian(s) First and Last Name Signature

*Signature Date

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PHYSICAL EXAMINATION FORM

PRINT CLEARLY WITH DARK BLACK INK.

Please clearly complete ALL required sections and place office stamp at the bottom of the page. Red asterisks (*) indicated required sections.

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Student Information

*Participant First and Last Name			
*Date of Birth		*HUID #	
PLEASE NOTE:			
<i>Licensed Health Care Provider, please take a moment to counsel the student on lifestyle and social issues associated with the college experience.</i>			

Required for Clearance				Recommended for Clearance		
*Height (in.):	*Temp:	*Pulse:		Hearing: Gross	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail
*Weight (lbs):	*BP:			Hearing: 15ft	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail
*Vision:	Corrected: Right 20/_____ Left 20/_____ Uncorrected: Right 20/_____ Left 20/_____			Hgb: _____	OR	HCT: _____%

Required for Clearance			
*Normal	*Check in appropriate column. <i>(Enter NE if not evaluated)</i>	*Abnormal	*Note: Describe abnormality. <i>(Enter item number before each comment.)</i>
	1. Head, face, neck and scalp		
	2. Nose		
	3. Mouth and throat		
	4. Ears - general		
	5. Eyes- general		
	6. Chest - general		
	7. Lungs		
	8. Breast		
	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 (Place supporting item numbers by diagnosis.)			
17. *Is there loss or seriously impaired function of any organs? If yes, explain:			<input type="checkbox"/> No <input type="checkbox"/> Yes
18. *Is the student under treatment for any medical or emotional condition? If yes, explain:			<input type="checkbox"/> No <input type="checkbox"/> Yes
19. *Is the student physically, mentally, and emotionally healthy? If no, explain:			<input type="checkbox"/> No <input type="checkbox"/> Yes
20. *Recommendations for physical activity (physical education, intramurals, etc.) If limited, specify limitations:			<input type="checkbox"/> Unlimited <input type="checkbox"/> Limited
21. *Has the student been advised and instructed on the proper use of their Epi Pen?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

LICENSED HEALTH CARE PROVIDER (All Sections Required)			
*Print Licensed Health Care Provider First and Last Name	*NPI Number	*Office Phone Number	*OFFICE STAMP <i>Required</i>
*Licensed Health Care Provider Signature (Non-Parental)		*Signature Date	

