HAMPTON UNIVERSITY INTERNATIONAL AND UKRAINIAN STUDENT MEDICAL CLEARANCE REQUIREMENTS

The following is required for medical clearance:

- Physical Examination Form (see attached form)
- Immunization Certificate (see attached form)
  - Parental consent is required for anyone under the age of 18
- Immunizations
  - **Varicella** (2 doses OR positive VZVIGG Titer)
  - **Meningitis A/C/W/Y** (one dose at or after the age of 16). Meningitis can be waived if age 22 or above by signing the attached waiver form.
  - **Polio** (4 doses or positive titer).
  - **Hepatitis B** (3 doses OR positive quantitative titer). Hepatitis B can be waived by signing the attached waiver form. Age under 18 years may waive with parent/guardian signature.
  - **TDaP Booster** (one dose within last 10 years).
  - **MMR** (Measles, Mumps, and Rubella) (2 doses or positive titer).
  - **TB** (tuberculosis) skin test with results within 48-72 hours and chest x-ray with results as indicated.
  - **COVID-19 Vaccine** card (First, second, and booster dose) .
    - COVID-19 Vaccine Manufacturer required

PLEASE NOTE: All medical documentation MUST be written in English. Students must put their HUID number on each document.

Please email all medical documentation to: **healthcenter@hamptonu.edu**

Hampton University Health Center
132 William R. Harvey Way, Hampton VA 23668
757-727-5315

HAMPTON UNIVERSITY

IMMUNIZATION CERTIFICATE

PRINT CLEARLY WITH DARK BLACK INK.
This form will be read by a computer.
Upload to medproctor.com

University: **Hampton University**

Student: DOB:

Green = Required
Blue = Recommended
Black = Optional

MMR Measles, Mumps, Rubella — Required
1st M M D D Y Y
2nd M M D D Y Y

MENINGOCOCCAL — Required
1st M M D D Y Y
2nd M M D D Y Y

COVID - 19 — Required
1st M M D D Y Y
2nd M M D D Y Y

COVID - 19 vaccine manufacturer

HEPATITIS B — Required
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

TDaP - Booster — Required
Within 10 yrs. M M D D Y Y

COVID - 19 Booster — Required
1st M M D D Y Y
2nd M M D D Y Y
Vaccine Manufacturer

VARICELLA - Chicken Pox — Required
1st M M D D Y Y
2nd M M D D Y Y

HEPATITIS A — Recommended
1st M M D D Y Y
2nd M M D D Y Y

POLIO - Inactivated — Required
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y
4th M M D D Y Y

INFLUENZA — Recommended
1st M M D D Y Y

HPV - Human Papillomavirus — Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

REQUIRED - Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE NON-PARENTAL	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NPI NUMBER *not required for U.S. service members or international students*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

RECOMMENDED - Tuberculosis Test Results

Tb Skin PPD
Placed: M M D D Y Y
Read: M M D D Y Y
actual induration in MM only m m

mm and range REQUIRED (fill bubble)
- ◯ 0 mm
- ◯ 0 to < 5 mm
- ◯ 5 to < 10 mm
- ◯ 10 to < 15 mm
- ◯ 15 mm or larger

OR

Tb Blood T-Spot QuantiFERON
Test M M D D Y Y

Results
- ◯ Positive
- ◯ Negative

Tuberculosis Test Results Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE NON-PARENTAL	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NPI NUMBER *not required for U.S. service members or international students*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

REQUIRED - Parent/Guardian Medical Treatment Consent

I hereby authorize Hampton University to employ diagnostic procedures and to render any treatment or medical, surgical, psychological or psychiatric care deemed necessary to the health and well-being of my child. I grant permission for the transfer of my child to an accredited hospital or other health care facility if deemed necessary by the medical or mental health provider.

PARENT/GUARDIAN SIGNATURE	PRINT PARENT/GUARDIAN FIRST AND LAST NAME	DATE OF BIRTH	SIGNATURE DATE

OFFICE STAMP

HAMPTON UNIVERSITY

Physical Examination

PRINT CLEARLY WITH DARK BLACK INK.
This form will be read by a computer.
Upload to medproctor.com

University: **Hampton University**

Student: DOB:

PLEASE NOTE:

This form must be completed clearly and signed by a Physician, Nurse Practitioner or Physician Assistant.
Provider, please take a moment to counsel the future college student on lifestyle and social issues associated with the college experience.

Height: ___ ___ **inches** Temp: ___ ___.___ Pulse: ___ ___ ___
Weight: ___ ___ ___.___ **pounds** BP: ___ ___ ___ / ___ ___ ___

Hearing: Gross Right ○ Pass ○ Fail Left ○ Pass ○ Fail
Hearing: 15 ft. Right ○ Pass ○ Fail Left ○ Pass ○ Fail

Vision: Corrected: Right 20/ ___ ___ Left 20/ ___ ___
Uncorrected: Right 20/ ___ ___ Left 20/ ___ ___

Hgb: ___ ___.___ OR Hct: ___ ___ %

			EXPLAIN ABNORMALITIES
General Appearance	○ NORMAL	○ ABNORMAL	
Head, Ears, Nose, Throat, Neck	○ NORMAL	○ ABNORMAL	
Eyes	○ NORMAL	○ ABNORMAL	
Respiratory	○ NORMAL	○ ABNORMAL	
Cardiovascular	○ NORMAL	○ ABNORMAL	
Mammary	○ NORMAL	○ ABNORMAL	
Gastrointestinal	○ NORMAL	○ ABNORMAL	
Hernia	○ NORMAL	○ ABNORMAL	
Genitourinary	○ NORMAL	○ ABNORMAL	
Musculoskeletal	○ NORMAL	○ ABNORMAL	
Metabolic / Endocrine	○ NORMAL	○ ABNORMAL	
Neuropsychiatric	○ NORMAL	○ ABNORMAL	
Skin	○ NORMAL	○ ABNORMAL	

Is there loss or seriously impaired function of any organ? ○ No ○ If yes
Explain : _____

Is the student under treatment for any medical or emotional condition? ○ No ○ If yes
Explain : _____

Recommendation for physical activity (physical education, intramurals, etc.) ○ Unlimited ○ If Limited
Specify limitations : _____

Is student physically mentally and emotionally healthy? ○ Yes ○ If no
Explain : _____

NOTES:

REQUIRED - Physical Examination Signature (Please place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE

NPI NUMBER *not required for U.S. service members or international students.*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

OFFICE STAMP

Hampton University: Meningitis Waiver

The University requires that all incoming students up to age 22 be immunized against meningococcal disease prior to enrollment. Please review the important information below regarding the disease. The Center for Disease Control and Prevention (CDC) advises the following regarding meningitis:

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Why college students should get vaccinated?

Meningococcal disease is a serious illness caused by a type of bacteria that can cause an infection of the brain, spinal cord or bloodstream. Bacterial meningitis can be deadly and kills 10-15 out of every 100 people who are infected. Of those who survive many suffer hearing loss, brain damage, kidney damage, amputations, nervous system problems, or severe scars from skin grafts. Viruses can also cause the disease but it tends to be less severe. College students at the highest risk for meningococcal disease are freshman and those living on campus.

What are the symptoms of meningitis?

Often the disease occurs without warning- even among people who are healthy. Meningitis is spread from person to person through close contact (coughing or kissing) or lengthy contact, especially among people living together. Symptoms of the disease can develop quickly over a few hours, or it may develop over 1-2 days. Symptoms are high fever, headache, stiff neck, nausea, vomiting and sensitivity to bright lights.

Meningococcal ACYW Vaccines

There are two kinds of vaccines recommended by the CDC for protection of college students; these vaccines offer protection for a range of 5 or more years. These vaccines do not protect from all of the strains of bacterial meningitis, but they do protect against the most prevalent ones. Two doses of one of the vaccines are recommended between the ages of 11 through 18. At least one of the doses should occur at age 16 or later. Risks associated with the vaccine include the following: redness, swelling, pain at the site of the injection, or severe allergic reaction which is rare. People with known allergic reaction to the components of the vaccine or who are pregnant or breastfeeding should not get the vaccine. If you have questions, please consult your doctor.

The vaccine is available locally at the Hampton Health Department, 3130 Victoria Blvd., Immunizations Clinic- call 757-727-1172, ext. 21717 for more information OR Walgreens, 500 Settlers Landing Rd, Hampton- call 757-723-7614 for more information.

TO WAIVE THE MENINGITIS VACCINE REQUIREMENT A WAIVER MUST BE SIGNED BY THE STUDENT AGE 22 or ABOVE:

I _____ HU ID #_____

(Print student's name)

have been provided detailed information about the risks associated with meningococcal disease by the Hampton University Health Center. Also, I am aware of the availability and effectiveness of the vaccines. After reviewing the information on the risks, I fully understand the disease can result in permanent brain damage, hearing loss, learning disability, limb amputation, kidney failure or death. At this time, I choose to waive the vaccination against meningitis.

Name_____ _____ **Date**_____

(Signature student)

2/17

Hampton University: Hepatitis B Waiver

The state of Virginia recommends all incoming freshman to colleges and universities be vaccinated against the Hepatitis B virus. Please review the important information below regarding the disease. A student or their parent/guardian may choose not to be vaccinated against Hepatitis B by signing and submitting the signed waiver. The Center for Disease Control and Prevention (CDC) advises the following regarding Hepatitis B:

Why should you get vaccinated against Hepatitis B?
Hepatitis B is a contagious liver disease that is caused by the hepatitis B virus. The disease causes an inflammation of the liver. Most of the people with the disease feel sick for a few weeks up to several months. Other people develop a lifelong infection that remains active in the bodies for a life time. These lifelong infections can cause liver cancer. College students should be immunized against Hepatitis B before they become sexually active.

What are the symptoms of Hepatitis B infection?
Hepatitis B symptoms include fatigue, loss of appetite, nausea, vomiting, diarrhea, abdominal pain and swelling, weight loss, dark urine, and yellow eyes and skin (jaundice). Usually symptoms occur within 90 days of exposure.

Hepatitis B is spread through blood and other body fluids that contain blood from infected individuals. College students should be immunized against Hepatitis B before they become sexually active. Infection can occur with unprotected sex with an infected person, sharing toothbrushes and razors, sharing needles when injecting illegal drugs, a needle stick injury at work, or an infant may be infected during vaginal childbirth from an infected mother.

Hepatitis B Vaccination
The vaccination series can provide up to 90% protection for prevention of the disease in adults. Three shots are given over the course of 6 months. Risks associated with the vaccine include the following: redness and swelling at the site of the injection, pain at the site of the injection, or severe allergic reaction which is rare. People with known allergic reaction to the components of the vaccine should not get the vaccine. If you have questions, please consult your doctor.

The vaccine is available locally at the Hampton Health Department, 3130 Victoria Blvd., Immunizations Clinic- call 757-727-1172, ext. 21717 for more information OR Walgreens, 500 Settlers Landing Rd, Hampton- call 757-723-7614 for more information.

TO WAIVE THE HEPATITIS B VACCINE REQUIREMENT A WAIVER MUST BE SIGNED BY THE STUDENT (OR SIGNED BY A PARENT/GUARDIAN IF UNDER AGE 17):

I _____ HU ID #_____
(Print student's name)
have been provided detailed information about the risks associated with the Hepatitis B virus by the Hampton University Health Center. Also, I am aware of the availability and effectiveness of the vaccines. After reviewing the information on the risks, I fully understand the disease can result in liver failure, liver cancer and death. At this time, I choose to waive the vaccination against meningitis.

Name_____ _____**Birth Date**_____
(Signature student/parent/guardian)