HAMPTON UNIVERSITY
132 William R. Harvey Way • Hampton, Virginia 23668 • Phone (757) 727-5315 • Fax (757) 728-6612 • Email: healthcenter@hamptonu.edu

Special Program - Medical Clearance Form

Name of Special Program _____

Start Date of Special Program _____ **HU ID# (if applicable)** _____

PLEASE PRINT OR TYPE

PERSONAL

Date: _____

Name _____
Last *First* *Middle Initial*

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

Telephone Number ( ) _____ Date of Birth _____
Area Code

Personal Email: _____

Name and relationship of emergency contact

Name _____
Last *First* *Middle Initial*

Relationship _____ Telephone Number ( ) _____
Area Code

PARENTAL CONSENT FOR MINORS

I give my consent for _____ to receive the medical care available to Special 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, V.P. - Student Success/Enrollment Management, 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)

Insurance Provider _____ Policy Number/ Subscriber Name _____ Group Number _____

The following questions are designed to protect YOUR HEALTH.

Personal History *(Check all that apply)*

A. Have you ever had (or have now):

[ ] Dizziness	[ ] Seizures	[ ] Racing of heart or palpitations
[ ] Severe headaches	[ ] Chest Pain	[ ] Asthma
[ ] Fainting or near fainting	[ ] Wheezing or coughing	[ ] Depression/Anxiety

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
[ ] High blood pressure	[ ] Severe sprains	[ ] Fractures
[ ] Heart failure	[ ] Marfan's Syndrome	[ ] Severe ligament injuries
[ ] Kidney disease	[ ] 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	

Signature _____
Participant/Guardian

PHYSICAL EXAMINATION

MUST BE COMPLETED ON UNIVERSITY FORM ONLY

(TO BE COMPLETED BY EXAMINER)

Name _____
Last *First* *Middle Initial*

Height _____ Blood Pressure _____

Weight _____ 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		

16. Remarks and pertinent history related to P.E. findings (Place supporting item numbers by diagnosis)

17. Recommendations – Further specialist examinations indicated (specify)

18. **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**