HAMPTON UNIVERSITY
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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

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. 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)

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**

IMMUNIZATION RECORD

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

Name _____
Last *First* *Middle Initial*

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

B. MMR (Measles, Mumps, Rubella)** ***(Required) **– Two doses required at least 28 days apart.**

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

C. 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 DAY YEAR
   Give date read and results (based on millimeters) ..... Date MONTH DAY YEAR _____ mm
2. ☐ Positive PPD – Chest x-ray required or IGRA results *(Please Attach).* Result: ☐ Positive ☐ Negative
   Give date and result of chest x-ray ..... Date MONTH DAY YEAR
3. ☐ Had BCG vaccine – Chest x-ray required if PPD not done or IGRA results *(Please Attach).* MONTH DAY YEAR

***D. POLIO**

1. ☐ Completed primary series of polio immunization ..... ☐ Yes ☐ No MONTH DAY YEAR
   Type of vaccine: ☐ OPV ☐ IPV
   Last booster ..... MONTH DAY YEAR

E. MENINGOCOCCAL MENINGITIS TETRAVALENT** *(Required* ***A, C, Y, W-135 *Groups)*

One dose must be given at age 16 or later.
All adolescents and teens ages 11-18 should be vaccinated, as should unvaccinated adults who are attending college.
Requirements are based on current CDC guidelines.

A booster dose is required for those who received their first dose before age 16:

☐ Menactra ..... MONTH DAY YEAR
or
☐ Menveo ..... MONTH DAY YEAR
or
☐ Menomuune ..... MONTH DAY YEAR

***F. VARICELLA** *(Required)*

☐ Dose 1 ..... MONTH DAY YEAR
☐ Dose 2 ..... MONTH DAY YEAR

G. HEPATITIS B** *(Required* ***or *Must Sign Waiver)*

☐ Dose 1 ..... MONTH DAY YEAR
☐ Dose 2 ..... MONTH DAY YEAR
☐ Dose 3 ..... MONTH DAY YEAR

Hepatitis B Waiver: I have reviewed the CDC website regarding Hepatitis B @ http://www.cdc.gov/hepatitis/index.html and have been fully informed of the risks and health hazards of Hepatitis B infection as well as the benefits of the Hepatitis B vaccine. I choose not to be immunized against the Hepatitis B infection at this time. I am aware that the shot is available at my local health department or retail pharmacy. Student signature (if under 18, parent or guardian must sign here):

Signature _____ Date _____

HEALTH CARE PROVIDER

Name _____ Address _____

Signature _____ Date _____ Phone (____) _____