

STUDENT HEALTH SERVICES

Virginia Union University Student Health Services is located on the second floor of the Henderson Center.

Student Health Services is open Monday-Friday 8:30 am to 4:30 pm. In the event that a student becomes ill or injured while Student Health Services is closed, the student may visit one of the local urgent care centers or an emergency room. The student is responsible for all fees incurred for services rendered. In case of an emergency the student should contact one of the following facilities:

Retreat Doctors’ Hospital (2621 Grove Avenue, Richmond, VA 23220)	804.254.5100
VCU Health System (1250 East Marshall Street, Richmond, VA 23219)	804.828.9000
Patient First (12 North Thompson Street, Richmond, VA 23221) 8:00 am –10:00 pm	804.359.1337

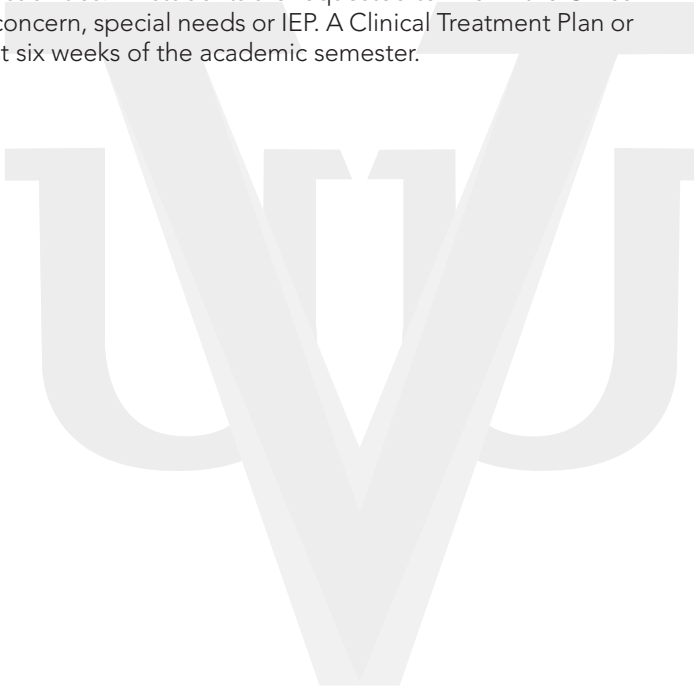
All students are required to complete the Student Health Evaluation Form. If you have any questions, please contact the Office of Student Health Services.

COUNSELING SERVICES

The Office of Counseling Services is located on the second floor of the Henderson Center, and may be reached at 804.342.3812. The office provides a range of professional counseling, preventative and educational services that support and address the development of students in a nurturing, safe, non-judgmental and confidential environment. Our purpose is to educate, support and empower students to overcome varied obstacles that may interfere with goals of successful matriculation. A variety of supportive services are provided to encourage and empower students to develop a sense of identity, integrity and purpose through successfully moving through autonomy, developing competence, managing emotions in a healthy manner and developing mature interpersonal relationships.

DISABILITY SERVICES

The Office of Disability Services is located in the Center for Student Success in Ellison Hall, Room 117. The Coordinator of Services for Students with Disabilities may be reached at 804.342.3885. Students seeking academic adjustments or accommodations, due to a disability, must self-identify with the Coordinator of Services for Students with Disabilities. Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 require the University to provide academic adjustments and/or accommodations for students with documented disabilities. After meeting with the Coordinator, students are encouraged to meet with their instructors to discuss their needs and if applicable, any lab safety concerns related to their disabilities. All students are requested to inform the Office of Disability and the Office of Counseling Services of any documented health concern, special needs or IEP. A Clinical Treatment Plan or an Academic Success Action Plan will be drafted for the student within the first six weeks of the academic semester.



By choosing to electronically sign the VUU Housing Contract below, you agree to the following Terms and Conditions:

I. Health History – To be completed by the student. (Required of all students)

Please answer all questions. Information requested in this form is strictly for the use of the Student Health Services in providing medical care and will not be released without your consent. Information gathered will not affect your status in any way.

Please print clearly in black ink:

VUU Student ID _____ Date of Birth _____ Age _____ Gender _____

Name _____
Last First Middle

Address _____
Street Apt. #

City State Zip

Home Phone Cell Phone Name of parent(s) or guardian

In case of emergency, notify _____

Address _____ Relationship _____

City _____ State _____ Zip Code _____ Phone _____

Name of insurance company _____ Subscriber _____

Policy number _____ Address _____

Personal History Significant Medical Conditions (dates and diagnoses):

Hospitalizations (dates and diagnoses): _____

Please check to indicate whether you have (or had in the past) these problems.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Migraine headache | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Substance/alcohol abuse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychological problems | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hepatitis or liver disease | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Tuberculosis or positive TB test |
| <input type="checkbox"/> Cancer or malignancy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> HIV | <input type="checkbox"/> Sickle Cell Trait | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney infection or stone | <input type="checkbox"/> Sickle Cell Disease | |
| <input type="checkbox"/> Gastrointestinal disorder | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Seizure disorder | |

Family History

Check if any of the following conditions exists in your family (immediate family, grandparents, aunts, uncles, and cousins).

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sudden death |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye disorder | <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other |

FOR SIGNATURE OF PARENTS/LEGAL GUARDIANS OR STUDENTS 18 YEARS OF AGE OR OLDER Virginia law requires parental permission in order to provide medical or surgical care to minors. Parents/legal guardian must sign the following consent statement to ensure medical care is carried out promptly without unnecessary delays. **RELEASE OF MEDICAL RECORDS:** I authorize the release of all medical records to Virginia Union University Student Health Services. I hereby authorize the physicians, clinicians, and staff nurses of Virginia Union University Student Health Services to examine, interview, test, and if necessary, treat my son/daughter/myself, as deemed advisable.

Signature _____ Date _____

II. Physical Examination – To be completed by the Licensed Health Professional (M.D., P.A., N.P.) performing the evaluation.

Please review the student's history (Part I), and provide additional details as needed. Please complete the physical exam and comment on all positive findings.

Please print clearly in black ink:

Name _____ VUU Student ID _____

Height _____ Weight _____ lbs. BP _____ Pulse _____ Vision R 20/ _____ L 20/ _____

Please record findings below. If abnormal please elaborate.

Examination Findings	Normal	Abnormal	Examination Findings	Normal	Abnormal
Head, Ear, Nose, Throat			Genitourinary		
Eyes			Back		
Respiratory			Extremities		
Cardiovascular			Skin		
Mammary			Surgical scars		
Gastrointestinal			Metabolic/endocrine		
Hernia			Neuropsychiatric		

Abnormal findings:

RECOMMENDED

Hct or Hgb _____ Urine _____ Alb. _____ Glu. _____ Micro. _____

REQUIRED (Please check)

DIAGNOSIS

☐ Excellent health with no chronic medical problems ☐ Other diagnosis and recommendation

Please list _____

REQUIRED (Please check)

PHYSICAL ACTIVITY

☐ Unlimited ☐ Limited

Explain _____

Allergies to Medications _____

Current Medications and Doses _____

Examiners Signature _____ Date of Exam _____

Print Name _____ Address _____

Phone (OFFICE) _____ Fax _____

IMPORTANT NOTICE: Failure to comply with the Commonwealth of Virginia's Immunization Laws will result in a Student Health HOLD being placed on your registration for the upcoming semester.

III. Immunization Record – To be completed by the Healthcare Provider.

Please print clearly in black ink:

Name _____

VUU Student ID _____

Date of Birth _____

Please attach a copy of immunization record(s).

		Month	Day	Year
Required by law	Polio series completed: yes no Last booster			
Required by law	Diphtheria/Tetanus/Pertussis completed primary series			
Required by law	Tetanus toxoid/diphtheria or Tdap (within ten years)			
Required by law; on or after first birthday	MMR (dose 1)			
Unless born prior to 1957	OR			
	Measles vaccine (dose 1)			
	Mumps			
	Rubella			
	AND			
Required by law	MMR (dose 2) (given at least 1 month after dose 1)			
	OR			
	Measles vaccine (dose 2)			
Required by law	Hepatitis B: Completion date			
Required by law	Meningococcal vaccine: (MCV4) Within 5 years. If last dose was received before the age of 16, revaccination is required.			
	Varicella series: 2 doses or history of disease			
	Varicella series:(dose 2)			

Please attach documentation of religious exemption from any of the required immunizations. All information must be in English.

☐ To the best of my knowledge, this person has received the above immunizations.

OR

☐ The physical condition of the above named individual is such that immunization could endanger life or cause death.

Please provide titer results for any immunizations that you can not show proof of receiving.

Signature of Health Professional _____ Date _____

Print Name _____ Address _____

Phone (OFFICE) _____ Fax _____

DOCTOR'S SEAL OR STAMP REQUIRED TO BE DEEMED VALID.

IMPORTANT NOTICE: Failure to comply with the Commonwealth of Virginia's Immunization Laws will result in a Student Health HOLD being placed on your registration for the upcoming semester.

IX. Tuberculosis Screening – the Licensed Health Professional (M.D., P.A., N.P.) performing the evaluation.

The following are the revised tuberculosis screening requirements at Virginia Union University. These are revised to reflect the updated recommendations published by the Centers for Disease Control in the MMWR, Vol. 49, June 9, 2000. Please answer all questions and sign below.

Please print clearly in black ink:

Name _____ VUU Student ID _____

All answers must be indicated on this form before it is considered complete; incomplete forms will be returned.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Traveled to Asia, Africa, Latin America, Eastern Europe, or Russia within the last 5 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Has the student had close contact with persons known or suspected of having tuberculosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Volunteered, been employed or been a resident of a correctional institution, nursing home, mental institution, homeless shelter or other long-term care facility serving high-risk clients? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Has the student been exposed to a household contact that meets any of the criteria numbers 2-5? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Was the student born outside of the United States? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PPD IS REQUIRED IF ANY OF THE ABOVE RESPONSES ARE YES

Date of PPD _____

Date of reading _____

Result _____ mm (provide actual size in mm, not just positive/negative) (Within last 12 months)

An induration greater than 5mm is considered positive.

If PPD, past or present, is positive-Chest x-ray is REQUIRED within the last 12 months: **(Quantiferon results are also accepted)**

Result (Please Attach Copy) _____

Treatment (medication prescribed and duration of treatment) _____

Any follow-up recommendations? _____

Signature of Health Professional _____ Date _____

Print Name _____ Phone (OFFICE) _____

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ALL SECTIONS OF THE FORM (I, II, III, AND IV) MUST BE COMPLETED AND RETURNED TO THE OFFICE OF STUDENT HEALTH SERVICES. INCOMPLETE FORMS WILL BE RETURNED.

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Please print clearly in black ink:

Name _____

VUU Student ID _____

Date of Birth _____

MENINGITIS

Meningitis is an infection of the fluid of the spinal cord and brain, caused by a virus or bacteria and usually spread through exchange of respiratory and throat secretions (i.e., coughing, kissing). Bacterial meningitis can be quite severe and may result in brain damage, hearing loss, or learning disability. A vaccine is currently available that effectively provides immunity for most types of bacterial meningitis, the more serious form, but there is no vaccine for viral type.

Waiver of Liability

I have received and read the information pertaining to meningitis. Despite the fact that I understand the risks involved, I refuse to receive the meningitis vaccine.

Signature of Student (or parent/legal guardian if under 18 years) Date _____

Signature of Witness Date _____

HEPATITIS B

Hepatitis B is a viral infection of the liver caused primarily by contact with blood and other bodily fluids from infected persons. Hepatitis B vaccine can provide immunity against hepatitis B infection for persons at significant risk, including people who have received blood products containing the virus through transfusions, drug use, tattoos, or body piercing; people who have sex with multiple partners or with someone who is infected with the virus; and health care workers and people exposed to biomedical waste.

Waiver of Liability

I have received and read the information pertaining to hepatitis B. Despite the fact that I understand the risks involved, I refuse to receive the hepatitis B vaccine.

Signature of Student (or parent/legal guardian if under 18 years) Date _____

Signature of Witness Date _____

NOTE: Virginia Union University assumes no liability for individuals electing not to be vaccinated for Meningitis or Hepatitis B.

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Return forms to:

Virginia Union University
Attn: Office of Student Health Services
1500 North Lombardy Street
Richmond, Virginia 23220

PREPARTICIPATION PHYSICAL EVALUATION

1. Have you had a medical illness or injury since your last check up or sports physical? Do you have an ongoing or chronic illness? ☐ Yes ☐ No
2. Have you ever been hospitalized overnight? ☐ Yes ☐ No
3. Are you currently taking a prescription, non-prescription (over the counter), medications, pills or using an inhaler? ☐ Yes ☐ No
4. Do you have any allergies (for example: to pollen, medicine, food, or stinging insects)? ☐ Yes ☐ No
 - a. Have you ever had a rash or hives develop during or after exercise? ☐ Yes ☐ No
5. Have you ever passed out during or after exercise? ☐ Yes ☐ No
 - a. Have you ever been dizzy during or after exercise? ☐ Yes ☐ No
 - b. Have you ever had chest pain during or after exercise? ☐ Yes ☐ No
 - c. Do you tire more quickly than your friends during exercise? ☐ Yes ☐ No
 - d. Have you ever had a racing of your heart or skipped beats? ☐ Yes ☐ No
 - e. Have you ever had high blood pressure or high cholesterol? ☐ Yes ☐ No
 - f. Have you ever been told that you have a heart murmur? ☐ Yes ☐ No
 - g. Has anyone in your family died of heart problems or a sudden death before the age of 50? ☐ Yes ☐ No
 - h. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? ☐ Yes ☐ No
 - i. Have you ever been knocked unconscious? ☐ Yes ☐ No
 - j. Has a physician ever denied or restricted your participation in sports for any heart problems? ☐ Yes ☐ No
6. Do you have any current skin problems? (example: itching, rashes, acne, warts, fungus, or blisters) ☐ Yes ☐ No
 - a. Have you ever been dizzy or passed out in the heat? ☐ Yes ☐ No
7. Have you ever had a head injury or a concussion? ☐ Yes ☐ No
 - a. Have you ever had a seizure? ☐ Yes ☐ No
 - b. Do you have frequent or severe headaches? ☐ Yes ☐ No
 - c. Have you ever had numbness, tingling in your arms, hands, legs or feet? ☐ Yes ☐ No
 - d. Have you ever had a stinger, tumor, or pinched nerve? ☐ Yes ☐ No
8. Have you ever become ill from exercising in the heat? ☐ Yes ☐ No
9. Do you cough, wheeze, or have trouble breathing during or after activity? ☐ Yes ☐ No
 - a. Do you have asthma? ☐ Yes ☐ No
 - b. Do you have seasonal allergies requiring medical treatment? ☐ Yes ☐ No
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your spots or position? (For example, knee brace, special neck roll, foot orthotics, retainer for teeth, hearing aid) ☐ Yes ☐ No
11. Have you had any problems with your eye or vision? ☐ Yes ☐ No
 - a. Do you wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No

(Continued on 5G)

12. Have you ever had a sprain, strain, swelling after injury? ☐ Yes ☐ No
- a. Have you ever broken or fractured and bones or dislocated any joints? ☐ Yes ☐ No
- b. Have you ever had any other problems with pain or swelling in muscles tendons bones or joints? ☐ Yes ☐ No
- c. If yes, check appropriate box and explain below ☐ Yes ☐ No
- | | | | |
|-----------------------------------|----------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Hand | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Back | <input type="checkbox"/> Elbow | <input type="checkbox"/> Finger | <input type="checkbox"/> Shin/Calf |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Forearm | <input type="checkbox"/> Hip | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Wrist | <input type="checkbox"/> Thigh | <input type="checkbox"/> Foot |
13. Are you happy with your weight now? ☐ Yes ☐ No
- a. Do you lose weight regularly to meet weight requirements for your sport? ☐ Yes ☐ No
14. Do you feel stressed out? ☐ Yes ☐ No
15. Record the dates of your most recent immunizations (shots) for:
- Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____
16. **FEMALES ONLY:** When was your first menstrual period? _____
- a. When was your most recent menstrual period? _____
- b. How much time do you usually have from the start of one period to the start of another? _____
- c. How many periods have you had in the last year? _____
- d. What was the longest time between periods in the last year? _____

Explain all "Yes" answers here:

Sickle Cell Test Results Needed (Please attach complete report)

Health Professional's Signature Date _____

DOCTOR'S SEAL OR STAMP REQUIRED TO BE DEEMED VALID.
Please make a copy of all health records before submission to VUU.