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 ____________________________________________

Address __________________________________________

City __________________________ State __________ Zip __________

Home Phone __________________________ Cell Phone __________________________

Name of parent(s) or guardian __________________________

In case of emergency, notify __________________________________________

Address __________________________________________

City __________________________ State __________ Zip Code __________

Name of insurance company __________________________

Policy number __________________________

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.

☐ Allergies ☐ Anemia ☐ Asthma ☐ Bleeding disorder ☐ Cancer or malignancy ☐ Chickenpox ☐ Diabetes ☐ Gastrointestinal disorder

☐ Hearing impairment ☐ Heart disease ☐ Heart murmur ☐ Hepatitis or liver disease ☐ High blood pressure ☐ HIV ☐ Kidney infection or stone ☐ Lung disease

☐ Migraine headache ☐ Pneumonia ☐ Psychological problems ☐ Rheumatoid arthritis ☐ Rheumatic fever ☐ Sickle Cell Trait ☐ Sickle Cell Disease ☐ Seizure disorder

☐ Sexually transmitted disease ☐ Substance/alcohol abuse ☐ Thyroid disorder ☐ Tuberculosis or positive TB test ☐ Visual impairment ☐ Other

Family History

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

☐ Allergies ☐ Anemia ☐ Asthma ☐ Bleeding disorder

☐ Cancer ☐ Diabetes ☐ Eye disorder ☐ Heart disease

☐ High blood pressure ☐ Lung disease ☐ Psychiatric disorder ☐ Stroke

☐ Sudden death ☐ Tuberculosis ☐ Ulcer ☐ 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 __________________________

Office of Student Health Services
Phone: 804.313.6045
Fax: 804.257.5622
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.

<table>
<thead>
<tr>
<th>Examination Findings</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Ear, Nose, Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Examination Findings Normal Abnormal
Genitourinary
Back
Extremities
Skin
Surgical scars
Metabolic/endocrine
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).

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

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? □ Yes □ No
2. Has the student had close contact with persons known or suspected of having tuberculosis? □ Yes □ 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? □ Yes □ No
4. Has the student been exposed to a household contact that meets any of the criteria numbers 2-5? □ Yes □ No
5. Was the student born outside of the United States? □ Yes □ 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) _______________________________

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

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.

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.
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 be vaccinated for Meningitis or Hepatitis B.

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.

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?  
   a. Have you ever broken or fractured and bones or dislocated any joints?  
   b. Have you ever had any other problems with pain or swelling in muscles tendons bones or joints?  
   c. If yes, check appropriate box and explain below
   □ Head  □ Neck  □ Hand  □ Knee  
   □ Back  □ Elbow  □ Finger  □ Shin/Calf  
   □ Chest  □ Forearm  □ Hip  □ Ankle  
   □ Shoulder  □ Wrist  □ Thigh  □ Foot

13. Are you happy with your weight now?
   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.