



Dear VWC Student:

Virginia Wesleyan College Health Services would like to take this opportunity to welcome you to VWC. We look forward to an exciting year. We understand that this is a busy time for new college students; however the following physical form paperwork **must** be completed before the school year begins. Please schedule an appointment with your doctor as soon as possible for your admission health evaluation and/or your athletic physical .

**\*All RESIDENT STUDENTS AND STUDENT ATHLETES** at Virginia Wesleyan College should complete the Medical History, Medical Examination, Insurance Information and Immunization forms (Forms A-D) and **return them to the Office of Health Services by mail.**

**\*All COMMUTER STUDENTS WHO ARE NOT ATHLETES** should complete forms A, C, and D. **Return forms to the Office of Health Services** by mail.

**\*TRANSFER ATHLETES** should complete the ENTIRE packet of forms (Forms A-D). All four (4) forms must be completed. **Return forms to the Office of Health Services.**

The student and/or student athlete can furnish most of the information. It is very important that all forms be filled out completely. **If you are an athlete, the athletic training staff will withhold you from practice/game participation if all of the requested documents are not completed!!**

**The deadline for return is August 1**

Form A- Medical History  
Form B- Medical Examination  
Form C- Insurance Information  
Form D- Immunization Form (2 pages)

*Return forms to:*

Virginia Wesleyan College  
Health Services.  
1584 Wesleyan Drive  
Norfolk, VA 23502

**\*\*Please mail health forms to Health Services (do not FAX) unless specifically requested!!**

The health forms may also be found on the Virginia Wesleyan College Home Page. Go to the Campus Life link and click on health services. [www.vwc.edu](http://www.vwc.edu)

Thank you,

Mary Cureton, R.N.  
Director of Health Services

Virginia Wesleyan College  
**ADMISSION AND PRE-PARTICIPATION PHYSICAL**  
 Required for Athletics and Residential Students  
Student must complete this side prior to physical examination.

Name \_\_\_\_\_, \_\_\_\_\_ Age \_\_\_\_\_  
 Last First  
 Social Security Number \_\_\_\_\_ Sex \_\_\_\_\_

Admission Status ( ) Freshman ( ) Transfer ( ) Returning Student ( ) Special \_\_\_\_\_ Date of Entrance \_\_\_\_\_

**Medical History**

- |                                                                                                                                                                                                     |       |       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------|
|                                                                                                                                                                                                     | Yes   | No    |
| 1. Do you have any allergies? ( <i>Drugs, Food, Insect Stings, etc.</i> )<br><i>If yes, list:</i> _____<br>If yes, Do you carry an Epi-pen? _____<br>If yes, Do you wear Medic-Alert jewelry? _____ | _____ | _____ |
| 2. Are you currently taking any drugs or medications including steroids or protein supplements?<br>( <i>Daily or occasionally</i> )<br><i>List:</i> _____                                           | _____ | _____ |
| 3. Are you presently being treated for any condition by a health care professional?<br><i>Explain:</i> _____                                                                                        | _____ | _____ |
| 4. Have you ever been advised by a provider not to participate in any sport/activity?<br><i>If yes, explain:</i> _____                                                                              | _____ | _____ |
| 5. Do you use any protective equipment/devices while playing sports?<br><i>If yes, explain:</i> _____                                                                                               | _____ | _____ |

6. Do you currently have any of the chronic conditions, disorders or diseases listed below? Check those applicable.

- |                                 |                              |                                                      |                           |              |
|---------------------------------|------------------------------|------------------------------------------------------|---------------------------|--------------|
| _____ Asthma                    | _____ Bleeding Disorders     | _____ Diabetes                                       | _____ Epilepsy (Seizures) | _____ Cancer |
| _____ Hepatitis (Liver Disease) | _____ Hypertension (High BP) | _____ Sickle Cell Anemia                             | _____ Mental Illness      | _____ Other  |
| _____ Mononucleosis Yr. _____   | _____ Heart Disease          | _____ Handicap or congenital disease(describe) _____ |                           |              |

Please check where applicable if you currently have or had in the past any of the following:

	Yes	No		Yes	No
Head injury, concussion, or been unconscious			Eye injury or retinal detachment		
Headaches more than once a week			Wear glasses or contact lenses		
Lack of feeling or numbness in any body part			Nose bleeds for no reason		
Heat exhaustion or heat stroke			False teeth, caps or braces		
Difficulty running 1/2 mile without stopping			Rash or skin problem		
Chest pain, dizziness or passing out during exercise			Missing or malfunction of any body part (eg. kidney, eye, ear, testicle)		
Coughing, wheezing or gasping for breath with exercise or cold weather			Severe viral infection (ie. Myocarditis or Mononucleosis) within the last month		
Smoke cigarettes or chew tobacco			Neck, spine or low back injury or pain		
Heart problem, murmur or arrhythmia			Lump(s) in arm pit or groin		
Family member with a heart attack or sudden death under age 50			Black or bloody bowel movements (stools)		
Loss or gain of more than 10 lbs. in last year			Diarrhea more than once a week		
Special diet for medical reasons			Kidney disease or dark, brown or bloody urine		
<i>Females: Date of last period:</i>			<i>Disabling cramps with menstrual periods</i>		
<i>Absent or irregular monthly periods</i>					

Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? If yes, check appropriate area and explain below. If you have sustained fractures in any of these areas, please check the appropriate area and explain below.

- Head  
  Neck  
  Back  
  Chest  
  Shoulder  
  Upper arm  
  Elbow  
  Forearm  
  Wrist  
  Hand  
 Finger  
 Hip  
 Thigh  
 Knee  
 Shin/Calf  
 Ankle  
 Foot

Within the last five years, have you been hospitalized (for medical or surgical reasons) or sustained an injury that did not allow you to participate in regular activities for more than a week? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide the following information:

INJURY OR MEDICAL PROBLEM	YEAR	RESOLVED	
		YES	NO

**I hereby state that I have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.**

STUDENT SIGNATURE _____	DATE _____	PARENT/ GUARDIAN SIGNATURE _____	DATE _____
		(IF STUDENT UNDER 18)	

**Form B**

Virginia Wesleyan College  
HEALTH SERVICES  
1584 Wesleyan Drive  
Norfolk, VA 23502  
PHONE: 757-455-3108

**MEDICAL EXAMINATION – To be completed by Health Care Provider**

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

*GENERAL EXAM*

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
	Arrhythmia	
	Murmur	
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		

<b>HEIGHT</b> _____ <b>WEIGHT</b> _____ <b>BP</b> _____ <b>PULSE</b> _____ <b>URINALYSIS:</b> _____protein _____blood _____glucose <b>VISUAL ACUITY:</b> _____RIGHT _____LEFT <b>Hemoglobin</b> _____ <b>OR</b> <b>Hematocrit</b> _____
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List any medications student uses: \_\_\_\_\_  
\_\_\_\_\_

List any life-threatening allergies: \_\_\_\_\_

Does this student carry an Epi-pen? YES NO

***ORTHOPEDIC EXAM***

MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

	Normal	Abnormal Findings
NECK		
SHOULDERS		
ARMS/HANDS		
HIPS		
THIGHS		
KNEES		
ANKLES		
FEET		

**PERTINENT HISTORY:**

**GENERAL SUMMARY OF PHYSICAL EXAMINATION:**

*CLEARANCE BASED UPON PHYSICAL EXAM AND REVIEW OF HISTORY (PLEASE ADD COMMENTS AS NEEDED TO OTHER SIDE)*

\_\_\_\_\_ Cleared for participation in intercollegiate athletics  
 \_\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_\_ NOT CLEARED FOR: \_\_\_\_\_ Collision \_\_\_\_\_ Contact \_\_\_\_\_ Non-contact

Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Name of Provider (print/type/stamp) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 \_\_\_\_\_

Signature of Provider \_\_\_\_\_ Date \_\_\_\_\_

**Form C**

**Insurance Information**

**PLEASE PROVIDE COPY OF HEALTH INSURANCE CARD,  
BOTH FRONT AND BACK**

**Immunization Record**  
TO BE COMPLETED BY ALL STUDENTS.

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

**Required: MMR, DPT, Polio, Meningitis vaccine & Tuberculosis Screening: others recommended.**  
**PHYSICIAN MUST STAMP AND VERIFY THIS SHEET!**

**A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)**

1. Dose I given at age 12-15 months or later..... #1 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr

2. Dose 2 given at age 4-6 or later, and at least one month after first dose..... #2 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr

**B. TETANUS-DIPHTHERIA** (Primary series with DTaP, DTP, DT or Td, and booster with Td or Tdap in the last ten years.)

1. Primary series of four doses with DTaP, DTP, DT, or Td:

#1 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      #2 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      #3 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      #4 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr

2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on patient age. Administer with MCV4 simultaneously if possible.)..... M \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
D Y

3. Tetanus-Diphtheria (Td) booster within the last ten years ..... M \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
D Y

**C. POLIO** (Primary series in childhood meets requirements; three primary series schedules are acceptable. Refer to ACIP for details.)

1. OPV alone (oral Sabin three doses): ..... #1 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      #2 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      #3 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr

2. IPV alone (injected Salk four doses): ..... #1 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      #2 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      #3 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      #4 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr

3. IPV/OPV sequential..... IPV #1 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      IPV#2 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      OPV#3 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      OPV #4 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr

**D. VARICELLA** (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 meets the requirement.)

1. History of Disease Yes \_\_\_\_\_ No \_\_\_\_\_ 2. Immunization Dose #1..... \_\_\_\_\_/\_\_\_\_\_  
Dose 2 \_\_\_\_\_/\_\_\_\_\_  
Dose 3 \_\_\_\_\_/\_\_\_\_\_  
Dose 4 \_\_\_\_\_/\_\_\_\_\_

**E. HEPATITIS B** (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)

1. Immunization

a. Dose #1 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      b. Dose #2 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr      c. Dose #3 \_\_\_\_\_/\_\_\_\_\_  
Mo Yr

2. Hepatitis B surface antibody Date \_\_\_\_\_/\_\_\_\_\_  
Results : Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_

**F. MENINGITIS VACCINE**

\_\_\_\_\_ / \_\_\_\_\_  
Mo Yr.      \_\_\_\_\_ quadravalent or \_\_\_\_\_ conjugate

**Form D cont.**

**G. TUBERCULOSIS SCREENING**

1. Does the student have signs or symptoms of active tuberculosis disease? Yes \_\_\_ No \_\_\_  
If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group? Yes \_\_\_ No \_\_\_  
If No, stop. If Yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.

3. Tuberculin Skin Test:  
Date Given: \_\_\_/\_\_\_/\_\_\_ Date Read: \_\_\_/\_\_\_/\_\_\_  
                  M D Y                   M D Y

Result: \_\_\_\_\_ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors):     positive\_\_\_ negative\_\_\_

4. Chest x-ray (required if tuberculin skin test is positive) result:     normal\_\_\_ abnormal\_\_\_

Date of chest x-ray: \_\_\_/\_\_\_/\_\_\_  
                          M D Y

**H. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)**

(Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.)

a. Dose #1 \_\_\_/\_\_\_/\_\_\_                   b. Dose #2 \_\_\_/\_\_\_/\_\_\_                   c. Dose #3 \_\_\_/\_\_\_/\_\_\_  
                  M D Y                                           M D Y                                           M D Y

**Physician Verification of Immunizations**

(Please place stamp here)

Physician's Signature \_\_\_\_\_  
Date \_\_\_\_\_

**Virginia Wesleyan College Health Services  
MENINGOCOCCAL VACCINE WAIVER**

I have read the information provided about meningococcal meningitis and understand the risks of the disease; however, I choose not to receive the vaccine.  
I understand that in the event of an outbreak, unvaccinated students will be at increased risk for contracting the illness.

Student's Printed Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

\_\_\_\_\_  
Signature of Student,

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date