PHYSICAL EXAMINATION

HEALTH FORM MUST BE COMPLETED AND RETURNED TO THE UNVERSITY PRIOR TO MOVING ON CAMPUS OR REGISTRATION. *Mail to:* STUDENT HEALTH SERVICES; UNIVERSITY OF THE VIRGIN ISLANDS, ST. THOMAS, V.I. 00802

INSTRUCTIONS:

1. Complete section by providing the requested information.
2. If you are under 18 years of age, have your parent or guardian complete section II.
3. Have your family physician fill out section III performing the required laboratory test.
4. Have your family dentist fill out section IV

Please be certain that ALL of the requested information has been supplied. An incomplete form will be returned to you and your admission to the University delayed.

I. INFORMATION (to be completed by the candidate for admission) DATE:_____ SOC SEC #_____

LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH | SEX

RESIDENTAL ADDRESS | STREET RUAL ROUTE | CITY | ISLAND/STATE

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) | ZIP CODE

PARENTS OR GUARDIANS NAME | HOME PHONE | BUSINESS PHONE

PARENTS OR GUARDINS RESIDENTIAL ADDRESS

II. MEDICAL CONSENT FORM (to be completed by the parent or guardian)

I, the undersigned (parent or guardian) do hereby grant permission to the University of the Virgin Islands Health Center (personnel university physicians and nurses, or the physician designated by the university physician) and/or the local hospital to administer any medical or surgical treatment to:

_____
NAME OF CANDIDATE FOR ADMISSON

during his/her enrollment at the University of the Virgin Islands. I also grant permission for his/her hospitalization and treatment therein, if such hospitalization is necessary.

I understood that in the event of a serious illness, accidental injury or need for surgery an attempt will be made by the university's health services to contact me by telephone. If unable to contact me, needed emergency treatment may be given as necessary in the best interest of the student.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN
SIGNATURE OF STUDENT (IF OVER 18) DATE

III. PHYSICAL EXAMINATION (to be completed by physician)

Candidate's Height_____ Weight _____ Blood Pressure_____
Distant Vision: right 20 _____ corrected 20 _____
Left 20 _____ corrected 20 _____

Color Vision (circle one) Normal Abnormal

Hearing (whispered voice at 10 feet) (circle one)

RIGHT: HEARD: NOT HEARD
LEFT: HEARD: NOT HEARD

Please circle any abnormalities of the following:

Skin	Lymph nodes	Head	Nose & Sinus	Eyes
Lungs & Chest	Heart	Vascular system	Spine	Ears
Endocrine System	Extremities	Feet	Abdomen	Neurological

If any of the above have been circled, please give and explanation: _____

_____

Has the candidate been treated, or is he being treated for any of the following: (circle)

Tuberculosis	Diabetes	Kidney Disease	Heart Condition	Anemia
Migraine	Asthma	Thyroid	Epilepsy	Rheumatic Fever

If candidate is now receiving care for any of the above please state treatment given, including diet, therapy, and or medications:_____

_____

Does the candidate have a history of injury or operation that may interfere with his course of study? (circle) Yes No. If "yes", please explain:

_____

Does the candidate have a history of any drug sensitivities? (circle) Yes No. If "Yes", please explain, and state counteracting medications found to be effective:_____

_____

According to my medical knowledge of the candidate: (check one)

a._____ He/She is fit for any physical activity.
b._____ He/She should be exempted from all strenuous physical activity.
c._____ He/She should be exempted from all physical activity.

If "b" or "c" is checked, for how long a period?_____

Has the candidate received any psychotherapy or been confined to a hospital for mental or emotional problems? (circle) Yes No. If "yes" explain: _____

Required Immunizations:

Type: Poliomyelitis_____ Date:_____
Tetanus-Series or Booster_____ Date:_____
Tuberculin Test_____ Date:_____
Negative Positive (If possible chest X-ray required)
First Second

Mumps: _____
Measles: _____
Rubella: _____

Required Laboratory Test:

Hemoglobin _____ Blood Type_____ Serology (circle one) Negative Positive
Urinalysis Sugar_____ Albumin _____ Stool for parasites (circle one) Negative Positive

If stool and/or blood examination was positive, have measures been taken to correct this? _____

_____

Physician's Signature:_____ Degree_____

Physician's Address:_____ Date_____

ATTENTION: AN ORIGINAL IMMUNIZATION RECORD AND ONE COPY MUST BE PROVIVED WITH THIS FORM.
THE ORIGNAL RECORD WILL BE RETURNED TO YOU.

IV. DENTAL EXAMINATION (to be completed by dentist)

A dental examination has been given this candidate and any corrective procedures necessary have been completed.
Dentist's Signature:_____ Dentist Address:_____
Date:_____