



STUDENT HEALTH FORM

(Physical Examination section to be completed by a medical provider)

FORM MUST BE COMPLETED AND UPLOADED TO THE MEDICAT PORTAL (<https://uvi.medicatconnect.com>) PRIOR TO MOVING ON CAMPUS

Contact Information: Health Services Center

Albert A. Sheen Campus (St. Croix)
RR#1 Box 10, 000 Kingshill
St. Croix, VI 00850-9781
(340) 692-4208 (Office)

Orville E. Kean Campus (St. Thomas)
#2 John Brewers Bay
St. Thomas, VI 00802-9990
(340) 693-1124 (Office)

INSTRUCTIONS:

- 1. Visit the Mediat portal (https://uvi.medicatconnect.com) and complete the
a. UVI Health History form
b. Texting Opt-in-Opt-Out form
c. Enter the immunization dates on immunization tab
d. Upload all health records including your physical exam, PPD (tuberculin skin test), and proof of vaccinations.
2. If you are under 18 years of age, a parent or guardian MUST complete and sign the Medical Consent Section of this Student Health Form.
3. Have a licensed medical provider (NP, MD, DO, or PA) fill out the physical examination section of this form including the required laboratory tests results.

MEDICAL CONSENT (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 Service Center (personnel, medical providers and nurses, or the medical provider designated by the campus physician) to provide medical and or surgical treatment to:

NAME OF CANDIDATE FOR ADMISSION

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

I understand that in the event of a serious illness, accidental injury or need for surgery, an attempt will be made by the University's Health Service Center to contact me by telephone. If unable to contact me, 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 YEARS OLD)

DATE
(mo / day / year)

PHYSICAL EXAMINATION SECTION

Student Name _____ DOB ____ / ____ / _____ Female ____ Male

Height _____ Weight _____ lbs BMI _____ Blood Pressure ____ / ____ T ____ P ____ R ____

Distance Vision: Right uncorrected: 20 / ____ Right corrected 20 / ____

Left uncorrected: 20 / ____ Left corrected 20 / ____

Color Vision: ____ normal ____ abnormal

Hearing (whispered voice at 10 feet): Right ____ heard ____ not heard

Left ____ heard ____ not heard

ALLERGIES: _____ SYMPTOMS: _____

SYSTEMS	NL	ABNL	NA	COMMENTS:
HEENT				
HEART				
LUNGS				
ABDOMEN				
EXTREMITIES				
NEURO				
SKIN				
GENITAL(General PR Only)				

CURRENT MEDICATIONS:

Name of Medication(s)	Dosage	How Often	Discontinued
1. _____			
2. _____			
3. _____			

CURRENT MEDICAL CONDITION(S) AND TREATMENT(S):

SURGICAL & PAST MEDICAL HISTORY:

ADDENDUM:

IMMUNIZATIONS: Required for all students

Please upload proof of all below vaccines, lab, and PPD test results to the Medcat Portal on the upload tab

Polio: ___ / ___ / ___ / ___ / ___ / ___ / ___ (3 doses acceptable)

Tetanus, Diphtheria, Pertussis: Primary series completed? Yes ___ No ___ Date of last dose in series: ___ / ___ / ___

Date of most recent booster dose: ___ / ___ / ___ Type of booster: Td ___ Tdap ___

MMR: ___ / ___ / ___ / ___ / ___

Hepatitis B: ___ / ___ / ___ / ___ / ___ / ___

Meningococcal Quadrivalent (ACYW-135): ___ / ___ / ___

****If Meningococcal ACYW is received before the age of 16, you will need one additional dose of the vaccine for residential living ___ / ___ / ___**

Varicella: (A history of chicken Pox, a positive varicella antibody or 2 doses of vaccines meet the requirement):

Dose #1 ___ / ___ / ___ Dose #2 ___ / ___ / ___ 1. History of Disease: Year ___ or age ___

2. Varicella antibody Date ___ / ___ / ___ Result Reactive ___ non-Reactive ___

PPD Skin Test is required for ALL students every 2 years. (Yearly for Nursing students in Clinicals).

PPD or TST (Tuberculin Skin Test) ___ / ___ / ___ PPD Reading: ___ / ___ / ___ mm Negative Positive

CXR Results (required for positive PPD): ___ INH Treatment rec'd ___ 3 mons ___ 6 mons ___ 9 mons

LABORATORY TEST RESULTS: CBC: ___ UA: ___ FBS: ___ Lab Slip Given

According to my review of systems, history, and physical examination of the student:

___ She/He/They are fit for any form of physical

___ She/He/They should be excused from participation in strenuous physical activity

___ She/He/They should be excused from participation in all forms of physical activity

MEDICAL PROVIDER NAME (Please Print)

SPECIALITY AREA

MEDICAL PROVIDER'S SIGNATURE: _____

DATE: _____
(mo / day / year)

MEDICAL PROVIDER'S ADDRESS: _____

UVI MEDICAL PROVIDER'S SIGNATURE: _____ **DATE:** _____
(mo / day / year)