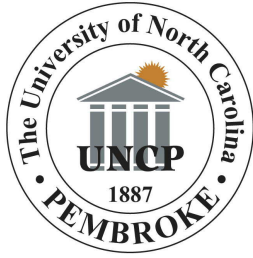


# THE UNIVERSITY OF NORTH CAROLINA AT PEMBROKE



## STUDENT HEALTH SERVICES

One University Drive  
Post Office Box 1510  
Pembroke, North Carolina 28372-1510  
(910) 521-6219  
FAX: (910) 521-6549  
<http://www.uncp.edu/shs>

*Congratulations on your admission to The University of North Carolina at Pembroke. As part of the admissions process you must complete this Student Health Form. Unless exempt, all new, transfer, and readmitted UNC Pembroke students **MUST** complete this form and return it to Student Health Services.*

**REGISTRATION WILL BE CANCELLED AND THE STUDENT WILL BE ADMINISTRATIVELY WITHDRAWN 30 calendar days after classes begin if the properly completed Health Form has not been received by Student Health Services.**

North Carolina state law (General Statute 130A 152-157) requires that all students entering college present a certificate of immunization, which documents that the student has received the immunizations required by law. This law applies to all students except the following: students residing off campus and registering for any combination of:

- a. Off-campus courses
- b. Evening courses
- c. Weekend courses
- d. No more than four traditional day credit hours in on-campus courses

### **IMPORTANT DEADLINE JULY 1<sup>st</sup>**

Return this form by July 1<sup>st</sup> if you are entering school for the fall semester. If you are entering The University of North Carolina at Pembroke for spring or summer sessions, or in the case of late acceptance, you must submit this form within 10 days of your acceptance notification. Please return any attached copies of immunization records in the same envelope.

### **INSTRUCTIONS/REQUIREMENTS**

**To comply with UNCP requirements and NC state law, please complete this health form as directed:**

- \* Pay careful attention to the "Guidelines for Completing Immunization Record" (following page). Section A lists NC State requirements. Give special attention to the requirements for a second Measles (Rubeola), and a tetanus booster or Tdap within the last 10 years.
- \* Recorded immunizations must be signed/documentated by a physician, a physician extender, or stamped from your local Health Department or clinic.
- \* Medical exemptions must be verified in a written statement by your physician.
- \* **Health Science students please note:** Your department may require additional immunizations. Please check with your department before turning in this health form.

**The UNCP Student Health Services is OPEN 24 HOURS** from Sunday at 5:00 p.m. through Friday at 4:00 p.m. and **CLOSED** from Friday at 4:00 p.m. until Sunday at 5:00 p.m. During the weekend a nurse is on-call. The UNCP Campus Police can be contacted in an **EMERGENCY** at 910-521-6235. For further details concerning visits to Student Health Services, please refer to your Student Handbook.

## **INFORMATION ABOUT THE MENINGOCOCCAL DISEASE AND THE MENINGOCOCCAL VACCINE**

The following information regarding the meningococcal disease and the meningococcal vaccine is based on guidelines established by the American College Health Association and the Centers for Disease Control and Prevention (CDC).

**MENINGITIS** is an inflammation of the membranes surrounding the brain and spinal cord and has a number of causes, including viral and bacterial. *Neisseria meningitidis* is one bacteria that may cause meningitis and strikes about 2,600 Americans each year, with an estimated 100-125 college students annually. Meningococcal bacteria are transmitted through the air via droplets of respiratory secretion, by oral contact with shared items, such as cigarettes or drinking glasses, by kissing, or by direct contact with an infected person. Meningococcal disease peaks in the late winter and early spring. It is possible to carry the bacteria in the nose or throat without symptoms. It is also possible for meningococcus to cause other infections of the body instead of meningitis, such as pneumonia.

If infected, a person may experience any of the following:

- high fever
- rash
- nausea
- vomiting
- severe headache
- neck stiffness
- lethargy
- light sensitivity

**TREATMENT** with antibiotics should begin as soon as the diagnosis is considered. Complications in survivors may include hearing loss, kidney failure, amputation of the limbs, and permanent brain injury. Meningococcal infection may, in some cases, be fatal.

**VACCINATION** against some serogroups of meningococcus exists. The vaccine is 85% effective against four serogroups of *Neisseria meningitides* (A, C, Y, and W-135) which account for 70% of college age students, and protection lasts for 3-5 years. It does not protect against serogroup B. Side effects of the vaccine are minimal and may include pain and redness at the injection site.

Decision about whether to receive or not receive the immunization should be based on knowledge of those at risk. Meningococcal disease can affect people at any age. Groups at increased risk include those in close contact with a known case, patients with compromised immunity, and persons traveling to endemic areas of the world. The risk of meningococcal disease in college students is similar to that of persons of the same age who are not in college (1.4-1.7 cases per 100,000 population). However, the risk appears increased in those living in dorms, especially freshmen, versus living off campus, and it is thought that living in confined environments facilitates spread of the disease.

Contact your personal physician for further information about meningitis and the vaccine's availability in your community.

If you wish to be vaccinated and are unable to be given the immunizations before you come to campus, the vaccine is available through Student Health Services during the fall semester.

# REPORT OF MEDICAL HISTORY

(Please print in black ink)

To be completed by student

LAST NAME (print) \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE/MAIDEN NAME \_\_\_\_\_ PERSONAL ID#(PID) \_\_\_\_\_ STUDENT ID # \_\_\_\_\_

PERMANENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ AREA CODE/PHONE NUMBER \_\_\_\_\_

DATE OF BIRTH (mo/day/yr) \_\_\_\_\_ GENDER  M  F MARITAL STATUS  S  M  OTHER \_\_\_\_\_ EMAIL \_\_\_\_\_

|   |   |  |
|---|---|--|
| CLASS YOU ARE ENTERING (circle):<br>FR. SO. JR. SR. GRAD. PROF. | PREVIOUSLY ENROLLED HERE <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, DATES _____<br>PREVIOUSLY A PATIENT HERE <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, DATES _____ | SEMESTER ENTERING (circle): FALL SPRING<br>SUMMER 1 SUMMER 2 OTHER YEAR 20____ |
|---|---|--|

|   |   |
|---|---|
| HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) _____ | AREA CODE/TELEPHONE NUMBER _____  |
| NAME OF POLICY HOLDER _____                                   | EMPLOYER _____  |
| POLICY OR CERTIFICATE NUMBER _____                            | GROUP NUMBER _____ IS THIS AN HMO/PPO/MANAGED CARE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO |

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ AREA CODE/PHONE NUMBER \_\_\_\_\_

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

## FAMILY & PERSONAL HEALTH HISTORY

(Please print in black ink)

To be completed by student

Has any person, related by blood, had any of the following:

|                            | Yes | No | Relationship |
|----------------------------|-----|----|--------------|
| High blood pressure        |     |    |              |
| Stroke                     |     |    |              |
| Heart attack before age 55 |     |    |              |
| Blood or clotting disorder |     |    |              |

|                                   | Yes | No | Relationship |
|-----------------------------------|-----|----|--------------|
| Cholesterol or blood fat disorder |     |    |              |
| Diabetes                          |     |    |              |
| Glaucoma                          |     |    |              |

|                       | Yes | No | Relationship |
|-----------------------|-----|----|--------------|
| Cancer (type):        |     |    |              |
| Alcohol/drug problems |     |    |              |
| Psychiatric illness   |     |    |              |
| Suicide               |     |    |              |

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

|                                   | Yes | No | Year |
|-----------------------------------|-----|----|------|
| High blood pressure               |     |    |      |
| Rheumatic fever                   |     |    |      |
| Heart trouble                     |     |    |      |
| Pain or pressure in chest         |     |    |      |
| Shortness of breath               |     |    |      |
| Asthma                            |     |    |      |
| Pneumonia                         |     |    |      |
| Chronic cough                     |     |    |      |
| Head or neck radiation treatments |     |    |      |
| Tumor or cancer (specify)         |     |    |      |
| Malaria                           |     |    |      |
| Thyroid trouble                   |     |    |      |
| Diabetes                          |     |    |      |
| Serious skin disease              |     |    |      |
| Mononucleosis                     |     |    |      |

|                                    | Yes | No | Year |
|------------------------------------|-----|----|------|
| Hay fever                          |     |    |      |
| Allergy injection therapy          |     |    |      |
| Arthritis                          |     |    |      |
| Serious head injury                |     |    |      |
| Frequent or severe headache        |     |    |      |
| Dizziness or fainting spells       |     |    |      |
| ADD                                |     |    |      |
| Paralysis                          |     |    |      |
| Disabling depression               |     |    |      |
| Excessive worry or anxiety         |     |    |      |
| Ulcer (duodenal or stomach)        |     |    |      |
| Intestinal trouble                 |     |    |      |
| Pilonidal cyst                     |     |    |      |
| Frequent vomiting                  |     |    |      |
| Gall bladder trouble or gallstones |     |    |      |

|                                    | Yes | No | Year |
|------------------------------------|-----|----|------|
| Jaundice or hepatitis              |     |    |      |
| Rectal disease                     |     |    |      |
| Severe or recurrent abdominal pain |     |    |      |
| Hernia                             |     |    |      |
| Easy fatigability                  |     |    |      |
| Anemia                             |     |    |      |
| Inherited blood disorder (Specify) |     |    |      |
| Eye trouble besides need glasses   |     |    |      |
| Bone, joint, or other deformity    |     |    |      |
| Knee problems                      |     |    |      |
| Recurrent back pain                |     |    |      |
| Neck injury                        |     |    |      |
| Back injury                        |     |    |      |
| Broken bone (specify)              |     |    |      |
| Kidney infection                   |     |    |      |
| Bladder infection                  |     |    |      |

|                               | Yes | No | Year |
|-------------------------------|-----|----|------|
| Kidney stones                 |     |    |      |
| Protein or blood in urine     |     |    |      |
| Hearing loss                  |     |    |      |
| Sinusitis                     |     |    |      |
| Severe menstrual cramps       |     |    |      |
| Irregular periods             |     |    |      |
| Sexually transmitted disease  |     |    |      |
| Blood transfusion             |     |    |      |
| Alcohol use                   |     |    |      |
| Drug use                      |     |    |      |
| Anorexia/Bulimia              |     |    |      |
| Smoke 1+ pack cigarettes/week |     |    |      |
| Regularly exercise            |     |    |      |
| Wear seat belt                |     |    |      |
| Other (specify)               |     |    |      |

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_  
 Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

**FAMILY & PERSONAL HEALTH HISTORY-CONTINUED** (Please print in black ink) To be completed by student

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

| Adverse Reactions to:                       | Yes | No | Explanation |
|---|-----|----|-------------|
| Penicillin                                  |     |    |             |
| Sulfa                                       |     |    |             |
| Other antibiotics (name)                    |     |    |             |
| Aspirin                                     |     |    |             |
| Codeine                                     |     |    |             |
| Other pain relievers                        |     |    |             |
| Other drugs, medicines, chemicals (specify) |     |    |             |
| Insect bites                                |     |    |             |
| Food allergies (name)                       |     |    |             |

|  | Yes | No | Explanation |
|--|-----|----|-------------|
| Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)                        |     |    |             |
| Have you ever been a patient in any type of hospital? (Specify when, where, and why)   |     |    |             |
| Has your academic career been interrupted due to physical or emotional problems? (Please explain)                                |     |    |             |
| Is there loss or seriously impaired function of any paired organs? (Please describe)   |     |    |             |
| Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe) |     |    |             |
| Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)      |     |    |             |

**IMPORTANT INFORMATION....PLEASE READ AND COMPLETE**

**STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):**

- (A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (student) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.
- (B) I hereby authorize any medical treatment for myself (student) that may be advised or recommended by Student Health Services.
- (C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student ID#

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian, if student under age 18

\_\_\_\_\_  
Date

# GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

**IMPORTANT** – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Be certain that your Name, Date of Birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and the year.

**Please Keep a Copy for Your Records.**

Acceptable Records of your Immunizations may be obtained from any of the following:

- **High School Records** – These may contain some, but not all of your immunization information. **Your immunization records do not transfer automatically. You must request a copy.**
- **Personal Shot Records** – Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- **Local Health Department**
- **Military Records of WHO (World Health Organization Documents)** - These records may not contain all of the required immunizations.
- **Previous College or University** – **Your immunization records do not transfer automatically. You must request a copy.**

## SECTION A:

### COLLEGE/UNIVERSITY VACCINES AND NUMBER OF DOSES REQUIREMENTS (For further information: <http://www.immunizenc.com/college.htm>)

| VACCINE REQUIRED<br><small>(REVIEW ALL FOOTNOTES BELOW)</small> | Diphtheria, Tetanus, and/or Pertussis <sup>1</sup> | Polio <sup>2</sup> | Measles <sup>3</sup> | Mumps <sup>4</sup> | Rubella <sup>5</sup> |
|---|--|--------------------|----------------------|--------------------|----------------------|
| DOSES REQUIRED  | <b>3</b>   | <b>3</b>           | <b>2</b>             | <b>2</b>           | <b>1</b>             |

**FOOTNOTE <sup>1</sup>** – DTP (Diphtheria, Tetanus, Pertussis), DTaP (Diphtheria, Tetanus, acellular Pertussis), Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, Pertussis): 3 doses of tetanus/diphtheria toxoid of which **one must have been within the past 10 years.**

Those individuals enrolling in college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid and a booster dose of tetanus/diphtheria/pertussis vaccine if a tetanus/diphtheria toxoid and tetanus/diphtheria/pertussis vaccine has not been administered with the past 10 years.

**FOOTNOTE <sup>2</sup>** – An individual attending school who has attained his or her 18<sup>th</sup> birthday is not required to receive polio vaccine.

**FOOTNOTE <sup>3</sup>** – Measles vaccines are not required if any of the following occur: Physician diagnosis of disease prior to January 1, 1994; an individual who has been documented by serological testing to have a protective antibody titer against measles and **submits the lab report**; or An individual born prior to 1957. An individual who enrolled in college or university for the first time before July 1, 1994 is not required to have a second dose of measles vaccine.

**FOOTNOTE <sup>4</sup>** – Mumps vaccine is not required if any of the following occur: An individual who has been documented by serological testing to have a protective antibody titer against mumps and **submits the lab report**; an individual born prior to 1957; or Enrolled in college or university for the first time before July 1, 1994. An individual entering college or university prior to July 1, 2008 is not required to receive a second dose of mumps vaccine.

**FOOTNOTE <sup>5</sup>** – Rubella vaccine is not required if any of the following occur: 50 years of age or older; Enrolled in college or university before February 1, 1989 and after their 30<sup>th</sup> birthday; an individual who has been documented by serological testing to have a protective antibody titer against rubella and **submits the lab report.**

**INTERNATIONAL STUDENTS and/or non-US Citizens:** Vaccines are required as noted above.

Additionally, these students are required to have a TB skin test administered with a negative result within the 12 months proceeding the first day of classes (chest x-ray required if test is positive).

## SECTION B

These vaccines are **RECOMMENDED**. Some may be required by certain departments. Consult your college or department for specific requirements.

North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Attached to this form is information regarding meningococcal disease, including recommendations from the Centers for Disease Control of the U.S. Public Health Service. Please record on the front of this form, whether or not you have received the meningococcal vaccine. If, yes, please note the month, day, and year of the vaccination.

## SECTION C

These vaccines are optional

# IMMUNIZATION RECORD

|                      |                   |                    |
|----------------------|-------------------|--------------------|
|                      |                   |                    |
| <b>Last Name</b>     | <b>First Name</b> | <b>Middle Name</b> |
| <b>Date of Birth</b> |                   | <b>Student ID#</b> |

Please print in black ink. To be completed and signed by physician or clinic. A complete official immunization record from a physician or clinic may be attached to this form. **Student to confirm identifying information above is complete before submission.**

| SECTION A Required Immunizations                  | mo/day/year | mo/day/year | mo/day/year                        | mo/day/year         | SUBMIT<br>LABORATORY<br>REPORT |
|---|-------------|-------------|------------------------------------|---------------------|--------------------------------|
| * DTP or Td or Tdap                               | (#1)        | (#2)        | (#3)                               | (#4)                |                                |
| <b>*Tdap booster (If due update after 7/2008)</b> |             |             |                                    |                     |                                |
| * Td booster                                      |             |             |                                    |                     |                                |
| * Polio   |             |             |                                    |                     |                                |
| * MMR (after first birthday)                      |             |             |                                    |                     |                                |
| * Measles/ Rubella (MR) ( after first birthday)   |             |             |                                    |                     |                                |
| * Measles (after first birthday)                  |             |             | ** Disease Date                    | Titer Date & Result |                                |
| * Mumps   |             |             | Not Acceptable<br>*** Disease Date | Titer Date & Result |                                |
| * Rubella   |             |             | Not Acceptable<br>*** Disease Date | Titer Date & Result |                                |

## SECTION B Recommended Immunizations

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

**Meningococcal vaccine: No ( ) Yes ( ) Which vaccine? Menactra ( ) Menomune ( ) Date given:**

|  | mo/day/year | mo/day/year | mo/day/year  | mo/day/year             |
|--|-------------|-------------|--------------|-------------------------|
| * Hepatitis B series only  | <b>OR</b>   |             |              | ****Titer Date & Result |
| * Hepatitis A/B combination series   |             |             |              |                         |
| *Varicella (chicken pox) series of two doses or immunity by positive blood titer         |             |             | Disease Date | ****Titer Date & Result |
| * Tuberculin Skin Test (PPD) Date read (within 12 months) Report result in mm induration |             |             |              |                         |
| Chest X-Ray, if positive PPD Date Results  |             |             |              |                         |
| Treatment if applicable Date   |             |             |              |                         |

| SECTION C Optional Immunizations | mo/day/year | mo/day/year | mo/day/year |
|----------------------------------|-------------|-------------|-------------|
| * Haemophilus influenzae type b  |             |             |             |
| * Pneumococcal                   |             |             |             |
| * Hepatitis A series only        |             |             |             |
| * HPV (Gardasil)                 |             |             |             |
| * Other                          |             |             |             |

### Signature or Clinic Stamp REQUIRED:

|  |              |       |          |
|--|--------------|-------|----------|
|  |              |       |          |
| Signature of Physician/Physician Assistant/Nurse Practitioner  | Date         |       |          |
|  |              |       |          |
| Print Name of Physician/Physician Assistant/Nurse Practitioner | Phone number |       |          |
|  |              |       |          |
| Office Address   | City         | State | Zip Code |

\*\* Must repeat Rubeola (measles) vaccine if received more than 4 days prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

\*\*\* Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

\*\*\*\* Lab Report must be submitted.