UNIVERSITY of NORTH CAROLINA
PEMBROKE

## Student Health Services

# REQUIRED
# Immunization & Medical History Form

North Carolina Law (General Statute 130A 152-157) requires documentation of immunizations within 30 days from the date of the student's first registration. Failure to comply will result in your classes being CANCELLED. 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.

• Pay attention to the "Guidelines for Completing Immunization Record."
• Please attach copies of any prior immunization records that document immunization compliance. These records must be on letterhead or signed by the provider/nurse that gave the immunizations.
• Students must complete and sign the Report of Medical History Form. If a student is under 18, their parent or guardian must sign the form.
• **A Physical Examination is not required for admission.**

Please complete this form and return it **PRIOR TO ORIENTATION** to

University of North Carolina Pembroke
Student Health Services
One University Drive
Pembroke, NC 28372
Phone: 910-521-6219
Fax: 910-521-6549
Website: www.uncp.edu/shs

**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.

## *REPORT OF MEDICAL HISTORY* *(Please print in black ink)* *To be completed by student*

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN NAME BANNER 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):

FR. SO. JR. SR. GRAD. PROF.

PREVIOUSLY ENROLLED HERE ☐ YES ☐ NO
IF YES, DATES _____

PREVIOUSLY A PATIENT HERE ☐ YES ☐ NO
IF YES, DATES _____

SEMESTER ENTERING (circle): FALL SPRING

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? ☐ YES ☐ 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<br>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.

(D) Registered students taking six (6) or more credit hours are required to purchase the Student Health Insurance Plan, with the following exceptions: distance education students (students taking off campus and Internet only courses) and students who submit evidence of equivalent coverage satisfactory to the policyholder may waive coverage. Visit www.bcbsnc.com/uncp to waive out of the University sponsored plan. Waiver deadlines vary each semester. Deadline information can be found at www.bcbsnc.com/uncp.

**Print Full Name of Student** _____ **Signature of Student** _____ **Date** _____

**Signature of Parent/Guardian, if student under age 18** _____ **Date** _____

*This publication is available in alternative formats upon request. Please contact: Accessibility Resource Center, D.F. Lowry Building, 910-521-6695.*

# GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

**IMPORTANT** – The immunization requirements must be met, or according to NC Law your classes will be cancelled until you are in compliance.

Be certain that your Name, Date of Birth and ID Number appear on each sheet and that all forms are mailed together. The dates of vaccine administration must include the month, day and year. Please keep a copy for your records.

**Acceptable records** of your immunization may be obtained from any of the following:

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

## REQUIRED VACCINATIONS

**Diphtheria, Tetanus and Pertussis: Three doses.** 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 or tetanus/diphtheria/pertussis vaccine has not been administered within the past 10 years.
Td titers not accepted for required tetanus.

**Polio: Three doses.** An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

**Measles: Two doses.** Measles vaccines are not required if any of the following occur: Diagnoses of disease prior to January 1, 1994; an individual who has been documented by serological testing to have a protective antibody titer against measles; or an individual born prior to 1957. An individual who enrolled in a college or university for the first time before July 1, 1994 is not required to have a second dose of measles vaccine.

**Mumps: Two doses.** 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; an individual born prior to 1957; or an individual enrolled in a college or university for the first time before July 1, 1994. An individual entering a college or university prior to July 1, 2008 is not required to receive a second dose of mumps vaccine.

**Rubella: One dose.** Rubella vaccine is not required if any of the following occur: 50 years of age or older; and individual is enrolled in a college or university before February 1, 1989 and after their 30th birthday; an individual who has been documented by serological testing to have a protective antibody titer against rubella.

**Hepatitis B**: **Three doses.** Hepatitis B vaccine is not required if an individual was born before July 1, 1994.

**MENINGITIS VACCINE:** North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Information about meningitis is available on the CDC website, the Student Health Center website, at the Student Health Center and at orientation. Please record on the Immunization Record whether you have received the meningococcal vaccine. If yes, please note the month, day and year of the vaccination as well as the type.

**INTERNATIONAL STUDENTS and/or non-US CITIZENS:** Vaccines are required as noted above. Additionally these students are required to have a TB skin test (PPD or TST) that has been administered with a negative result by a U.S. facility within 12 months prior to the first day of class. A chest x-ray result is required if the test is positive.

# *UNIVERSITY OF NORTH CAROLINA PEMBROKE - IMMUNIZATION RECORD*

| | | |
|---|---|---|
| | | |

Last Name First Name Middle Date of Birth ( MM/DD/YYYY ) Personal ID# (PID)

## *SECTION A REQUIRED IMMUNIZATIONS*

**All students must submit documentation of 3 DTP, Td or Tdap vaccines regardless of age. One MUST be a Tdap.**

| **Immunization Name** | MM/DD/YYYY | MM/DD/YYYY | MM/DD/YYYY | MM/DD/YYYY |
|---|---|---|---|---|
| DTaP/DTP/Td (Diphtheria/Tetanus/Pertussis or Tetanus/Diphtheria Toxoid) | | | | |
| Tdap booster (All Students MUST show proof of a Tdap booster) | | | | |
| Polio (3 doses, only required if 17 years of age or younger) | | | | |
| MMR (Measles, Mumps, Rubella – 2 MMR vaccines required on or after first birthday OR 2 Measles, 2 Mumps and 1 Rubella single doses OR positive Measles, Mumps, Rubella titers) | | | | |
| Measles (2 required on or after first birthday OR positive titer OR documented disease date) | | | Disease Date | **Titer Date & Result |
| Mumps (2 required on or after first birthday OR positive titer) | | | (Disease Date NOT Accepted) | **Titer Date & Result |
| Rubella (1 required on or after first birthday OR positive titer) | | | (Disease Date NOT Accepted) | **Titer Date & Result |
| Hepatitis B Series (only required if born after July 1, 1994) | | | | **Titer NOT Accepted for required Hep B Series** |

## *SECTION B RECOMMENDED IMMUNIZATIONS*

| **Immunization Name** | | MM/DD/YYYY | MM/DD/YYYY | MM/DD/YYYY | MM/DD/YYYY |
|---|---|---|---|---|---|
| Has the student received the Meningococcal vaccine (Menactra, Menveo, Menomune, MPSV4, MCV4)? ☐ Yes ☐ No | | | | | |
| If **Yes**, date(s) received - **Booster dose recommended at age 16** | | | | | |
| Meningococcal B vaccine (Bexsero or Trumenba - Please discuss risks and benefits of this vaccine with your medical provider) | | | | | |
| Hepatitis A | | | | | |
| Hepatitis A/B combination series | | | | | |
| Pneumococcal | | | | | |
| Human Papillomavirus (HPV) | Cervarix | | | | |
| | Gardasil | | | | |
| | Gardasil-9 | | | | |
| Varicella (2 doses, documentation of disease date or positive titer) | | | | Disease Date | **Titer Date & Result |
| Tuberculin Skin Test (TST) | Date Read | | | | |
| | mm induration | mm | mm | mm | mm |
| | Date of IGRA (QuantiFERON or T-SPOT) test | | | **Chest X-ray Date | |
| | Result of IGRA test | ☐Positive ☐Negative | ☐Positive ☐Negative | **Chest X-ray Result | ☐Positive ☐Negative |

** Must attach a copy of all laboratory and Chest X-ray results

**Signature and Credentials of Health Care Provider** **Date**

**Printed Name and Credentials of Health Care Provider** **Area Code/Phone Number**

**Office Address** **City** **State** **Zip Code**