A Division of Student Affairs

Student Health and Counseling Services

Dear Student:

The Student Health and Counseling Services (SHCS) at NORTH CAROLINA CENTRAL UNIVERSITY looks forward to serving you.

30 days prior to enrollment at the University, the accompanying medical history form which includes an official record of immunizations must be submitted to SHCS. A physical examination is also encouraged.

North Carolina Public Health Law requires proof of immunizations to protect you and others while at North Carolina Central University. A person shall present a certificate or record of immunization on or before the date the person first registers for a semester during which the student will reside on the campus or first register for four or more credit hours. If a certificate or record of immunization is not in the possession of Student Health and Counseling Service on the date of first registration, the University shall present a notice of deficiency to the person.

Please attach copies of any records that will verify your immunizations. This information can be obtained from multiple sources including pediatrician, parents, armed services, high school, previous college or University, foreign travel and/or other health department records. Keep a copy of all immunization records for your personal files.

Failure to provide your completed immunization record by the deadline date will result in your classes being dropped and loss of your financial aid.

Please provide your Social Security number. All international students must provide their temporary ID number if they do not have a Social security number.

Student Health services provides a variety of medical and other health care services that can be viewed on our web site at Student Health and Counseling:

http://www.nccu.edu/students/studentservices/healthandcounseling/index.cfm

For more information about the immunization requirement, go to: www.immunizenc.com/college.htm

The regular administrative office hours are Monday-Friday from 8:00 a.m. to 5:00 p.m. Our telephone number is 919-530-6317 and the fax number is 919-530-7969.

Respectfully yours,

Student Health and Counseling Services

NORTH CAROLINA CENTRAL UNIVERSITY • P.O. BOX 19491 • DURHAM, NC 27707• (919) 530-6317 • FAX (919) 530-7969

NORTH CAROLINA CENTRAL UNIVERSITY IS A CONSTITUENT INSTITUTION OF THE
UNIVERSITY OF NORTH CAROLINA

GUIDELINE FOR COMPLETING IMMUNIZATION RECORD

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

Acceptable Records of Your immunizations May be Obtained from Any of the Following: (Be certain that your name and Social Security/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 year. **Keep a copy for your records**.)

- High School Records – There may contain some, but not all of your immunization information. Contact Student Health for help if needed.
- 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 or WHO (World Health Organization Documents).
- Previous College or University – Your immunization records do not transfer automatically. You must request a copy.

SECTION A:	**IMMUNIZATION REQUIREMENTS ACCORDING TO AGE**
1. STUDENTS 17 YEARS OF AGE OR YOUNGER	11. STUDENTS BORN IN 1957 OR LATER AND 18 18 YEARS OR AGE OR OLDER
Vaccine Required	Vaccine Required
3 DTP (*Diphtheria-Tetanus-Pertussis*) or Td (*Tetanus-Diphtheria*) doses. 1 TD (*Tetanus-Diphtheria*) dose must be within the last 10 years. 3 POLIO (*oral*) does. 2* MEASLES (*Rubeola*) one dose on or after 12 months of age, the 2nd after 15 months of age. (2 MMR doses meet this requirement) 1** RUBELLA (*German measles*) dose. 2** MUMPS 3** HEPATITIS B (**Required if born 7/1/94 or after**)	3 DTP (*Diphtheria-Tetanus-Pertussis*) or Td (*Tetanus-Diptheria*) doses. 1 TD (*Tetanus-Diphtheria*) *dose* must be within the the last 10 years. 2* MEASLES (*Rubeola*) one dose on or after 12 months of age, the 2nd after 15 months of age. (2 MMR doses meet this requirement.) 1** RUBELLA (*German measles*) dose. 2** MUMPS
III. STUDENTS BORN PRIOR TO 1957 AND 49 YEARS OF AGE OR YOUNGER	**IV. STUDENTS 50 YEARS OF AGE AND OLDER**
Vaccine Required	Vaccine Required
3 *DTP (Diphtheira-Tetanus-Pertussis) or Td (Tetanus-Diphtheria)* doses. 1 Td (*Tetanus-Diphtheria*) dose must be within the last 10 years. (If a Td booster is the only dose you document, it must be clearly marked as a booster. 1** RUBELLA (*German measles*) dose.	3 DTP (*Diphtheria-Tetanus-Pertussis*) or Td (*Tetanus-Diptheria*) doses. 1 Td (*Tetanus-Diphtheria*) dose must be within the last 10 years. (If a Td booster is the only dose you document, it must be clearly marked as a booster.)
V. INTERNATIONAL STUDENTS	
Vaccine Required	
Vaccines required according to age (refer to appropriate box). Additionally, International students are required to have a TB skin test and negative result within the 12 months preceding the first day of classes (chest x-ray required if test is positive).	

* Must repeat Rubeola (measles) vaccine if received even one day 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, mumps disease, or Hepatitis B is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from physician, is not acceptable.

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

SECTION C:	These vaccines are **OPTIONAL.**

** Required*

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

LAST NAME (print) FIRST NAME MIDDLE NAME *SOCIAL SECURITY NUMBER

PERMANENTADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo/day/yr) _____ GENDER ☐ M ☐ F MARITAL STATUS ☐ S ☐ M ☐ OTHER

CLASS YOU ARE ENTERING (circle): FR. SO. JR. SR. GRAD. PROF.

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

SEMESTER ENTERING (circle): FALL SPRING SUMMER1 SUMMER2 OTHER YEAR20

BANNER ID #: _____

NAME OF PERSON TO CONTACT IN CASE OF AN 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 acle 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			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilondal 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 or Sickle Cell Anemia			
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 stone			
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 and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

~ Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

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** Required*

FAMILY AND 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? (Is 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 a 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, 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 (son/daughter's) 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 (my son/daughter's) that may be advised or recommended by the physicians of the Student Health Service. (Not applicable to community colleges)

(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. (Not applicable to community colleges)

(D Students taking 6 or more credit hours of campus classes are required to have health insurance. Students with private insurance can "waive out" of the University sponsored plan and have their account credited by visiting student insurance.com and completing an on-line waiver. Waiver deadlines vary each semester. Deadline information can be found at student insurance.com.

Signature of Student **Date**

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

(*Encouraged but not Required*)

PHYSICAL EXAMINATION *(Please print in black ink)* *To be completed and signed by physician or clinic*

A physical examination is required by some schools and/or programs (consult your college or department for specific requirements). If required, it must be completed in black ink and signed by a physician or clinic.

Last Name First Name Middle Name	Date of Birth (mo/day/year)	* Social Security Number

Permanent Address City State Zip Code	Area Code/Phone Number

Height _____ Weight _____ TPR _____/_____/_____ BID _____/_____

IF REQUIRED:	IF REQUIRED:
Vision: Corrected Right 20/ _____ Left 20/ _____	Urinalysis: Sugar: _____ Albumin _____
Uncorrected Right 20/ _____ Left 20/ _____	Micro _____
Color Vision _____	Hab or Hct (if indicated) _____
Hearing (gross) Right _____ Left _____	STS (may be required by some departments)
15 ft. Right _____ Left _____	Date _____ Results _____
	Recommendations

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
Explain _____

D. Is student physically and emotionally healthy? Yes _____ No _____
Explain _____

• Only for Students Admitted to a HEALTH SCIENCES PROGRAM •

Based on my assessment of this student's physical and emotional health on _____ (Date), he/she appears able to participate in the activities of a health profession in a clinical setting. Yes_____ No_____ if no, please explain _____

Signature of Physician/Physician Assistant/Nurse Practitioner _____ Date _____

Print Name of Physician/Physician Assistant/Nurse Practitioner _____ Area Code/Phone Number _____

Office Address City State Zip Code

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IMMUNIZATION RECORD	(Please print in black ink) To be completed and signed by physician or clinic A complete immunization record from a physician or clinic may be attached to this form.

Last Name First Name Middle Name	Date of Birth (mo./day/year)	*Social Security Number

SECTION A REQUIRED IMMUNIZATIONS				
	mo./day/year	mo./day/year	mo./day/year	mo./day/year
• DTP or Td	(#1)	(#2)	(#3)	(#4)
• Td Booster				
• Polio				
• MMR (after first birthday)				
• MR (after first birthday)				
• Measles (after first birthday)			**Disease Date	Titer Date & Result
• Mumps			***(Disease Date NOT Accepted)	Titer Date & Result
• Rubella			***(Disease Date NOT Accepted)	Titer Date & Result
• Hepatitis B (for students born after 7/1/94)	(#1)	(#2)	(#3)	

SUBMIT LABORATORY REPORT

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.

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
• Hepatitis B series				
• Varicella (chicken pox) series of two doses or immunity by positive blood titer				
• Meningococcal				
• Tuberculin (PPD) Test Date read				
(within 12 months) 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 influenza type b			
• Pneumococcal			
• Hepatitis A Series			
• Typhoid (specify type)			
• Other			

Signature or Clinic Stamp REQUIRED:

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

_____

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

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*** Only laboratory proof of immunity to rubella, mumps, and hepatitis B disease is acceptable if the vaccine is not taken. History of rubella, mumps, and hepatitis disease, even from physician, is not acceptable.