University of North Carolina Wilmington
Abrons Student Health Center

REQUIRED
Immunization & Medical History Form

North Carolina Law 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.

- 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. If a student is taking a physical education course and has a medical condition that may affect participation then a student will be asked for documentation of a physical within the past 14 months or required to get one done.

Please complete this form and return it PRIOR TO ORIENTATION to

University of North Carolina Wilmington
Abrons Student Health Center
601 S. College Road
Wilmington, NC 28403

Phone: 910-962-3280
Fax: 910-962-4130

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.

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 at an appropriate medical facility within the 12 months prior to the first day of class. A chest x-ray result is required if the test is positive.

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

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

PERMANENT ADDRESS 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 SUMMER 1 SUMMER 2 OTHER YEAR 20__

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

NAME OF POLICY HOLDER *SOCIAL SECURITY NUMBER EMPLOYER

IS THIS AN HMO/PPO/MANAGED CARE PLAN? ☐ YES ☐ NO

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

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 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 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			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides 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 us 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.

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 (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) 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.)

Signature of Student **Date**

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

IMMUNIZATION RECORD

Last Name	First Name	Middle Name	Date of Birth	Student ID#

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	
DTP or Td or Tdap	(#1)	(#2)	(#3)	(#4)	
Tdap booster (If booster done after 7/2008)					
Td booster					
Polio					
MMR (after first birthday)					
Measles/ Rubella (MR) (after first birthday)					
Measles (after first birthday)			* Disease Date	Titer Date & Result	SUBMIT LABORATORY REPORT
Mumps **				Titer Date & Result	
Rubella **				Titer Date & Result	
Meningococcal vaccine: No ( )Yes( ) Which vaccine? Menactra ( ) Menomune ( ) Date given:					

SECTION B Recommended Immunizations

The following immunizations are recommended for all students and may be required by certain colleges or departments. 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 only OR				*** 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 placed				
Date read				
Report result in 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.

FORM UPDATED 5/2008

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/yr)	*Social Security Number

Permanent Address	City	State	Zip Code	Area Code/Phone Number

Height _____ Weight _____ TPR _____ / _____ / _____ BP _____ / _____

IF REQUIRED:

Vision: Corrected Right 20/ _____ Left 20/ _____

Uncorrected Right 20/ _____ Left 20/ _____

Color Vision _____

Hearing: (gross) Right _____ Left _____

15 Ft. Right _____ Left _____

IF REQUIRED:

Urinalysis: Sugar: _____ Albumin _____

Micro _____

Hgb or Hct (if indicated) _____

STS (may be required by some departments)

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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