GUILFORD
COLLEGE

STUDENT HEALTH SERVICES IMMUNIZATION FORM

P / 336.316.2194
F / 336.316.2184

FALL 2023

A completed immunization record is required to be submitted to Student Health prior to registration for courses.
This form is due by July 1.

You may bring your completed form to your orientation event.
At any other time:

- Email: studenthealth@guilford.edu
- Fax: 336.316.2184
- Mail: Guilford College Student Health Services,
  5800 West Friendly Avenue,
  Greensboro, NC 27410

If mailing, remember to keep a copy for your records

North Carolina Law G.S. 130A-155 requires persons attending college to present an immunization record. Required immunizations are listed in Section A. Please make a copy for your records.

Students not meeting these requirements must be immunized during the initial 30 days of the semester or be removed from the College.

We request all students have current immunizations before coming to the College.

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT

- Your immunization records may be obtained from your physician, health department or previously attended college. These records may not fulfill all requirements. **It is your responsibility to assure compliance with required immunizations**. If you are a resident of North Carolina, you may submit a copy of your records from the NC Immunization Registry.
- **The records must list student's name, date of birth, sex, and address; all dates must include month, day and year of administration, and signed/stamped by doctor's office or Health Department.**
- **Our form (page 3 of this document) may be used to complete the immunization record.**
- **Please receive all immunizations before coming to campus.**
- Keep a copy of your Immunization Record and this document for your records.

SECTION A

IMMUNIZATIONS THAT ARE **REQUIRED** PURSUANT TO NC STATE LAW AND INSTITUTIONAL POLICY FOR TRADITIONAL STUDENTS:

- 4 DTP (Diphtheria, Tetanus, Pertussis) or (Tetanus, Diphtheria) doses; **one Td booster or Tdap must have been within the past 10 years**.
- 3 polio (oral) doses.
- 2 measles, mumps, rubella **(2 MMR doses meet this requirement)**.
- Hepatitis B series (3 doses required) - Blood titer is not acceptable.
- 1 dose Varicella (if born on/after 4/1/2001). Blood titer is acceptable.

Notes:

- Blood titer tests are acceptable for Measles (Rubeola), Mumps, Rubella and/or Varicella. Laboratory test results must be attached.

International Students:

You are considered an international student if you were born outside the United States, currently live outside of the US, or have lived outside the United States for three months or more. If any of these situations apply, **- you are required to have a TB test.** If the TB test is positive, you must have proof of a negative chest X-ray, treatment documentation (if required), no active symptoms and a note from your physician stating that you do not have active TB.

You must also have all your immunizations completed before arrival:

- 4 DTP (Diphtheria, Tetanus, Pertussis) or (Tetanus, Diphtheria) doses; **one Td booster or Tdap must have been within the past 10 years**.
- 3 polio (oral) doses.
- 2 measles, mumps, rubella **(2 MMR doses meet this requirement) *or*** blood titer test showing positive immunity to all three - signed by a physician.
- Tuberculin Skin Test (PPD) and result within the **twelve months preceding** the beginning of classes (chest x-ray report required if test is positive).
- Hepatitis B series (3 doses required) - Blood titer is not acceptable.
- 1 Varicella (if born on/after 4/1/2001). Blood titer is acceptable.
- A Physical Examination is also required. Please use our form.
- Records must be complete in English.
- Keep a copy for your records.

SECTION B

THESE VACCINES ARE RECOMMENDED BY GUILFORD COLLEGE, BUT ARE NOT REQUIRED.

REQUIRED FOR ALL STUDENTS: IMMUNIZATION RECORD

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

Last Name First Name Middle Name Date of Birth (mo./day/year)

Sex Address

SECTION A: REQUIRED IMMUNIZATIONS

All dates must have month/day/year	mo./day/year	mo./day/year	mo./day/year	mo./day/year
▪ DPT or Td (series of 4)				
▪ Td or Tdap Booster within the last 10 years (circle one)				
▪ Polio (series of 3)				
▪ MMR (2 doses) (Measles, Mumps & Rubella) *If submitting titer results, original lab document is required*				
▪ Hepatitis B series (series of 3)				* Titer not accepted
▪ Varicella (1 dose if born on/after 4/1/2001)				
▪ Tuberculin (PPD) Test (within 12 months) Date read **(For international students only)**				
mm induration				
Chest x-ray, if positive PPD Date read *(ATTACH PHYSICIAN'S NOTE)* Results				
Treatment, if applicable Date				** attach lab report

SECTION B: RECOMMENDED IMMUNIZATIONS - The following immunizations are recommended for all students, but are not required.

	mo./day/year	mo./day/year	mo./day/year	
▪ COVID-19 Vaccine (2 Doses and Booster)				
Manufacturer				
▪ Meningococcal B (Bexsero or Trumbenbo)				
▪ Meningococcal (Menactra, Menveo, Monomune)				** attach lab report
▪ Haemophilus Influenzae type b				
▪ Pneumococcal				
▪ Hepatitis A				
▪ Gardasil				

Signature or Clinic Stamp REQUIRED:

Signature of Physician / Date

Print Name of Physician / Area Code / Phone Number

Office Address

REQUIRED FOR ALL STUDENTS
REPORT OF MEDICAL HISTORY

(Please print in black ink) ***To be completed and signed by student***

LAST NAME (print) FIRST NAME MIDDLE NAME

PERMANENT ADDRESS CITY STATE ZIP AREA CODE / PHONE

E-MAIL ADDRESS CELL PHONE #

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

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

PREVIOUSLY ENROLLED HERE ❑ YES ❑ NO

SEMESTER ENROLLING (circle): FALL SPRING

Guilford College requires that all students are covered by a medical insurance plan. Please complete this information and/or attach a (front and back side) copy of your current medical health insurance card(s).
For more information, go to www.guilford.edu/StudentHealth.

HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE / PHONE

NAME OF POLICY HOLDER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON AND TELEPHONE TO CONTACT IN CASE OF AN EMERGENCY RELATIONSHIP

PARENT WORK NUMBER

ARE YOU COVERED IN NC TO SEE A DOCTOR OR URGENT CARE FOR OTHER THAN EMERGENCY? ❑ YES ❑ NO

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.

Height_____ Weight_____

Have you had or have you now: *(please check at right of each item)*

	Yes	No
ADD / ADHD		
Alcohol use		
Allergy injection therapy		
Anemia or Sickle Cell Anemia		
Anorexia / Bulimia		
Anxiety		
Autism Spectrum Disorder		
Asthma		
Bipolar Illness		
Blood transfusion		

	Yes	No
Concussion		
Depression		
Diabetes		
Drug use		
Epilepsy / Seizures		
Frequent/Migraine headaches		
Hay fever / Allergies		
Heart trouble		
High blood pressure		
Intestinal trouble		
Mononucleosis		

	Yes	No
Other learning disability		
Pilonidal cyst		
Sexually transmitted disease		
Smoke 1+ pack cigarettes/wk		
Tuberculosis		
Tumor or cancer (specify)		
Thyroid trouble		
Ulcer (duodenal or stomach)		
Other (specify)		

Please list any drugs, medicines, birth control pill, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

1_____ 3_____

2_____ 4_____

PERSONAL HEALTH HISTORY, CONTINUED (Please print in black ink) *To be completed by student*.

Check each item "Yes" or "No." Every item checked "Yes" explain in the space on the right.

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (specify)			
Require an epi-pen			

	Yes	No	Explanation
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 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 by Court order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student Health Services to release information from my (son/daughter's) medical record to physician, hospital, or other medical agency involved in providing me (him/her) with emergency treatment and/or medical care.

Signature of Student Date

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

REQUIRED FOR INTERNATIONAL STUDENTS ONLY: PHYSICAL EXAMINATION **AND** TB SKIN TEST

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

Last Name First Name Middle Name Date of Birth (mo./day/year)

Permanent Address City State Zip Code Area Code/Phone Number

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

Vision	Corrected	Right 20/_____	Left 20/_____	**Urinalysis**	Sugar _____ Albumin _____
	Uncorrected	Right 20/_____	Left 20/_____		Micro _____
	Color Vision			**Hgb or Hct** (if indicated) _____	
Hearing		(gross) Right _____	Left _____	**TB Skin Test Results (mandatory)** _____	
		15 ft. Right _____	Left _____	*If positive, chest x-ray report is required*	

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

Signature of Physician/ Physician Assistant/Nurse Practitioner Date

Signature of Physician/ Physician Assistant/Nurse Practitioner Area Code/Phone Number

Office Address

IMPORTANT INFORMATION ABOUT MENINGOCOCCAL DISEASE

Meningococcal Disease is caused by bacteria called Neisseria meningitides and is spread from person to person through respiratory secretions. Some individuals can be infected with the bacteria and yet not exhibit no symptoms. They are unaware of the infection, yet can spread it to others. Others who are exposed to these bacteria will get significant infection, sometimes resulting in death. If the bacteria invade the bloodstream or other body tissues it can cause meningitis (inflammation of the membranes surrounding the brain and spinal cord), sepsis (infection of the blood stream), pneumonia, or pharyngitis (sore throat).

Studies show that freshmen entering college and residing in residential halls are at an increased risk of this disease, relative to other persons of similar age. Due to this, it is recommended by the Center of Disease Control (CD) that this vaccine is offered for other college students wanting to reduce their risk of this disease.

The vaccinations available that prevent Meningitis do not contain live bacteria. They are 85-90% effective in preventing disease from serotypes A, C, and Y and W-35, but they do not protect against the serotype B. There is now a specific vaccine that does provide protection against serotype B. Ask your health care provider to health department about this additional Meningitis vaccine.

Guilford College recommends that students discuss the Meningitis vaccines with their primary care provider or local health department prior to coming to college. The vaccinations are also available from Greensboro area medical providers and the Guilford County Health Department.

For more information about this disease and the vaccines contact:

- https://immunize.nc.gov/family/pdf/more_information_about_meningitis_and_meningococcal_vaccine.pdf
- The Center for Disease Control: https://www.cdc.gov/meningitis/index.html
- American College Health Association: www.acha.org