

# **ELIZABETH CITY STATE UNIVERSITY**

## **STUDENT HEALTH SERVICES**

1704 Weeksville Road \* Campus Box 885  
Elizabeth City, N.C. 27909



Main Number  
252-335-3267

Fax  
252-335-3269

Congratulations on your acceptance to the Elizabeth City State University and welcome to Student Health Services. North Carolina Law (General Statute 130A-152) requires that all students entering a college or university must present a “certificate of immunization” on or before the first day of registration.

Who needs to complete this form?

- All students taking more than four credit hours on the university campus must provide documentation of having received all required immunizations and comply with university policies and procedures for submission of health forms.

When is this form due?

- This form must be received and completed in its entirety **NO LATER THAN JULY 15<sup>TH</sup> FOR FALL ENROLLMENT, DECEMBER 4<sup>TH</sup> FOR SPRING ENROLLMENT, AND MAY 1<sup>ST</sup> FOR SUMMER ENROLLMENT.**
- Please complete this attached form and mail to Student Health Services in the enclosed self addressed envelope.

Exceptions:

- ECSU does not require a physical examination.
- ECSU does not require a TB skin test except for international students from Non-European countries.
- Medical Exemptions from immunizations must be requested and signed by a physician.

Where can you get immunization information?

- Your Physician
- Your Local Health Department
- ECSU Student Health Services (For re-entering students only)

OTHER IMPORTANT INFORMATION

- Be certain to include your Social Security Number. If you are an international student, include your temporary ID number.
- Pay careful attention to the Guidelines for Completing Immunization Record.
- Copies of immunization cards may be submitted. These copies must be in their entirety with the name of the clinic/health department and/or physician signatures included.
- The Family and Personal Health Record **MUST BE SIGNED BY THE STUDENT AND/OR THE PARENT, IF THE STUDENT IS A MINOR.**

Please note that if these immunization requirements are not met, dismissal from school is mandatory under North Carolina law!

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**IMPORTANT - The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.**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

<b>SECTION A:</b>	<b>COLLEGE/UNIVERSITY VACCINES AND NUMBER OF DOSES REQUIRED</b> <i>(For further information: <a href="http://www.immunizenc.com/college.htm">http://www.immunizenc.com/college.htm</a>)</i>				
<b>VACCINE REQUIRED</b> <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>
<b>DOSES REQUIRED</b>	3	3	2	2	1

**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 within the past 10 years.

**FOOTNOTE <sup>2</sup>** – An individual attending school who has attained his or her 18th 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 30th 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 preceding the first day of classes (chest x-ray required if test is positive).

<b>SECTION B:</b>	<b>The vaccines are RECOMMENDED. Some may be required by certain departments. Consult your college or department for specific requirements.</b>
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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.

<b>SECTION C:</b>	<b>These vaccines are OPTIONAL</b>
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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. **Students to confirm identifying information above is complete before submission.**

Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	Student ID#
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<b>SECTION A REQUIRED IMMUNIZATIONS</b>				
	mo./day/year	mo./day/year	mo./day/year	mo./day/year
	(#1)	(#2)	(#3)	(#4)
• DTP or Td or Tdap				
• Tdap booster (If due update after 7/2008)				
• Td booster				
• Polio				
• MMR (after first birthday)				
• Measles/Rubella <i>MR</i> (after first birthday)				
• Measles (after first birthday)			** Disease Date	**** Titer Date & Result
• Mumps			Not Acceptable *** Disease Date	**** Titer Date & Result
• Rubella			Not Acceptable *** Disease Date	**** Titer Date & Result

**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.

**Meningococcal Vaccine** No  Yes  Which Vaccine? Menactra  Menomune  Date Given:

	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) Test Date read (within 12 months) Report Results 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 influenza 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.

Do Not Write In This Space



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 an adverse reaction (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 Reaction 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 THE AGE OF 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 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 my 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 the age of 18

\_\_\_\_\_  
Date



***Elizabeth City State University is committed to equality of educational opportunity and does not discriminate against applicants, students, or employees based on race, color, national origin, religion, gender, age, or disability***