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IMPORTANT - The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.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

SECTION A:	COLLEGE/UNIVERSITY VACCINES AND NUMBER OF DOSES REQUIRED  (For further information: http://www.immunizenc.com/college.htm)					
VACCINE REQUIRED (REVIEW ALL FOOTNOTES BELOW)		Diphtheria, Tetanus, and/or Pertussis <sup>1</sup>	Polio <sup>2</sup>	Measles <sup>3</sup>	Mumps <sup>4</sup>	Rubella ⁵
DOSES REQUIRED		3	3	2	2	1

**FOOTNOTE** 1 – DTP (Diphtheria, Tetanus, Pertussis), DTaP (Diphtheria, Tetanus, acellular Pertussis), Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, Pertussis): 3 doses of tetanus/diphtheria toxoid of which <u>one must have been within the past 10 years</u>.

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 2 - 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>6</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 proceeding the first day of classes (chest x-ray required if test is positive).

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

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.

SECTION	These vaccines are <b>OPTIONAL</b>	
C:		

IMMUNIZATION RECORD	(Please print in black in clinic may be attached	nk) To be completed and si to this form. <b>Students to</b>	igned by physician or clinic. confirm identifying inform	A complete immunization reation above is complete	ecord from a physician or before submission.
ast Name First Na	me N	liddle Name Da	ate of Birth (mo./day/yea	ar) Student ID#	
ECTION A REQUIRED IMMUNIZ	ZATIONS				
		mo./day/year	mo./day/year	mo./day/year	mo./day/year
DTP or Td or Tdap		(#1)	(#2)	(#3)	(#4)
Tdap booster (If due update af	ter 7/2008)				
Td booster					
Polio					
MMR (after first birthday)					
Measles/Rubella MR (after first	st birthday)			7	
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 Repo
e following immunizations are reco alth sciences). Please consult your eningococcal Vaccine No	college or departm	ent materials for sp	required by certain coecific requirements.  actra   Menomune		nts (for example,
•		mo/day/year	mo/dov/voor	I mo/dov/voor	T
Honotitia Dinamina anti-		mo/day/year	mo/day/year	mo/day/year	****Titas Data 9 Daa
Hepatitis B series only					****Titer Date & Res
OR					
Hepatitis A/B combination serie					
Varicella (chicken pox) series of		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Disease Date	****Titer Date & Res
or immunity by positive blood					
Tuberculin Skin Test (PPD) Tes					
(within 12 months) Report Results					
Chest x-ray, if positive PPD	Date Results				
Treatment if applicable					
пеантент п аррисавте	Date				
ECTION C OPTIONAL IMMUN	IZATIONS				
		mo/day/year	mo/day/year	mo/day/year	
Haemophilus influenza type b					
Pnuemococcal					
Hepatitis A series only					
HPV (Gardasil)					
Other					1
gnature or Clinic Stamp REQUIRED:					
gnature of Physician/Physician Assis	tant/Nurse Practition	ner	Da	ite	
int Name of Physician/Physician Ass	istant/Nurse Practition	oner	Ph	one Number	
fice Address	City			State	Zip Code
Must repeat Rubeola (measles) vaccacceptable, but must have signed stoner of immunity to physician, is not acceptable.	atement from physicia	n.			
* Lab Report must be submitted.					
	Do	Not Write In This S	pace		

#### FAMILY & PERSONAL HEALTH HISTORY -CONTINUED (Please print in black ink) To be completed by student LAST NAME (print) FIRST NAME MIDDLE NAME UNC PERSON ID # (PID) \*SOCIAL SECURITY NUMBER PERMANENT ADDRESS ZIP CODE AREA CODE/PHONE NUMBER STATE DATE OF BIRTH (mo./day/yr)\_ MARITAL STATUS S M OTHER GENDER MM F E-MAIL PREVIOUSLY ENROLLED HERE YES NO CLASS YOU ARE ENTERING (circle): SEMESTER ENTERING (circle): SPRING FALL IF YES, DATES FR. SO. JR. SR. GRAD. PROF. PREVIOUSLY ENROLLED HERE YES NO SUMMER 1 SUMMER 2 OTHER YEAR 20\_ IF YES, DATES HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER EMPLOYER NAME OF POLICY HOLDER \*SOCIAL SECURITY NUMBER \_ IS THIS AN HMO/PPO/MANAGED CARE PLAN? 🔲 YES 🔲 NQ POLICY OR CERTIFICATE NUMBER GROUP NUMBER NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP ADDRESS CITY STATE ZIP CODE AREA CODE/TELEPHONE NUMBER The following 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 and of the following YES NO Relationship YES YES NO Relationship NO Relationship High blood pressure Cholesterol or blood Cancer (type): fat disorder Diabetes Alcohol/drug problems Psychiatric illness Heart attack before age Glaucoma Blood or clotting disorder Suicide WEIGHT. Have you ever had or do you have now: (please check at right of each item and if yes, indicate year of first occurrence) YES NO YEAR YES NO YEAR YES NO YEAR YES NO YEAR Jaundice or hepatitis Kidney stones High blood pressure Hay fever Rectal Disease Protein or blood in Allergy injection Rheumatic fever therapy urine Heart trouble Arthritis Severe or recurrent Hearing loss Pain or pressure in Concussion Sinusitis Hemia chest Shortness of breath Frequent or sever Severe menstrual Easy fatigability headache Anemia or Sickle Asthma Dizziness or fainting Irregular periods Cell Anemia spells Eve trouble besides Sexually transmitted Pneumonia Serious head injury need glasses Chronic cough Bone, joint, or other Paralysis Blood transfusion deformity Head or neck Disabling depression Kňee problems Alcohol use radiation treatments Drug use Tumor or Cancer Excessive worry or Recurrent back pain (specify) anxiety Ulcer (duodenal or stomach) Anorexia/Bulimia Malaria Neck injury Thyroid trouble Smoke 1+ pack Back injury Intestinal trouble cigarettes/week Diabetes Broken bone Regularly exercise Pilonidal cyst (specify) Serious skin disease Frequent vomiting Wear seat belt Kidney infection Gall bladder Other (specify) Mononucleosis Bladder infection 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 Name Use Dosage \_\_\_\_ Dosage Name Use Dosage \_ Name Use Dosage Dosage \_ Name Use Name Use Dosage Use Dosage Use Name 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.

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.

			men the reaction occurred, and it the experience has occurred more than once.
Adverse Reaction to: Penicillin	Yes	No	Explanation
Sulfa			
Other antibiotics (name)			
Aspirin	<del>                                     </del>		
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)			·
IMPORTAN*	T INFC	RMA	TIONPLEASE READ AND COMPLETE
STATEMENT BY STUDENT (OR PA	RENT/GU	IARDIAN	I, IF STUDENT UNDER THE AGE OF 18):
<ul> <li>(A) I have personally supplied (revision I understand that the information otherwise permitted by law. If I stouch to the institution to release infor professional involved in providir</li> <li>(B) I hereby authorize any medical of the Student Health Service.</li> <li>(C) I am aware that the Student Heacount is not paid at the time of incurred charges. I am response</li> </ul>	ewed) the in is strictly should be mation from treatment Not applicable for its it. I ac nsible for its it.	above in y confide ill or injust of my (so n/her) with for mysecable to coe charge except per filing out	Information and attest that it is true and complete to the best of my knowledge.  Intial and will not be released to anyone without written consent, unless ared or otherwise unable to sign the appropriate forms, I herby give my permission on/daughter's) medical record to a physician, hospital, or other medical the emergency treatment and/or medical care.  If (my son/daughter) that may be advised or recommended by the physicians
Signature of Student			Date
Signature of Parent/Guardian, if stude	ent 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