

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 15TH FOR FALL ENROLLMENT, DECEMBER 4TH FOR SPRING ENROLLMENT, AND MAY 1ST 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IMPORTANT - The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (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 year. **Keep a copy for your records.**)

- High School Records - These may contain some, but not all of your immunization information. Contact Student Health for help if needed. **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 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 | | | | |
|--|---|-----------------------------|-------------------------|---------------------------|--|
| STUDENTS 17 YEARS OF AGE AND YOUNGER | | | | | |
| DTP or Td ¹ 3 | Polio 3 | Measles ² 2 | Mumps ⁴ 1 | Rubella ⁴ 1 | |
| STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER | | | | | |
| DTP or Td ¹ 3 | Polio 0 | Measles ^{2,3} 2 | Mumps ⁴ 1 | Rubella ⁴ 1 | |
| STUDENTS BORN BEFORE 1957 | | | | | |
| DTP or Td ¹ 3 | Polio 0 | Measles 0 | Mumps 0 | Rubella ⁴ 1 | |
| STUDENTS 50 YEARS OF AGE AND OLDER | | | | | |
| DTP or Td ¹ 3 | Polio 0 | Measles 0 | Mumps 0 | Rubella 0 | |
| INTERNATIONAL STUDENTS | | | | | |
| Vaccine Required | | | | | |
| Vaccines are 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) | | | | | |

1. DTP (Diphtheria, Tetanus, Pertussis), Td (Tetanus, Diphtheria): One Td booster within the last ten years
2. Measles: One dose on or after 12 months of age; second at least 30 days later. 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.
3. Two measles doses if entering college for the first time after July 1, 1994.
4. One dose on or after 12 months of age. Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a 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. |
|-------------------|--|

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.

| | |
|-------------------|------------------------------------|
| SECTION C: | These vaccines are OPTIONAL |
|-------------------|------------------------------------|

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 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 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/GAURDIAN, IF STUDENT UNDER THE AGE OF 18):

- (A) I have personally supplied (received) 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 filling 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/Gaurdian, if student under the age of 18

Date

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 _____ CITY _____ STATE _____ ZIP CODE _____ AREA CODE/PHONE NUMBER _____

DATE OF BIRTH (mo./day/yr) _____ GENDER M F MARITAL STATUS S M OTHER _____ E-MAIL _____

CLASS YOU ARE ENTERING (circle):
 FR. SO. JR. SR. GRAD. PROF.
 PREVIOUSLY ENROLLED HERE YES NO
 IF YES, DATES _____
 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 _____
 POLICY OR CERTIFICATE NUMBER _____ GROUP NUMBER _____ IS THIS AN HMO/PPO/MANAGED CARE PLAN? YES NO

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 |
|----------------------------|-----|----|--------------|
| 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 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 |
|-----------------------------------|-----|----|------|------------------------------|-----|----|------|------------------------------------|-----|----|------|-------------------------------|-----|----|------|
| High blood pressure | | | | Hay fever | | | | Jaundice or hepatitis | | | | Kidney stones | | | |
| Rheumatic fever | | | | Allergy injection therapy | | | | Rectal Disease | | | | Protein or blood in urine | | | |
| Heart trouble | | | | Arthritis | | | | Severe or recurrent abdominal pain | | | | Hearing loss | | | |
| Pain or pressure in chest | | | | Concussion | | | | Hernia | | | | Sinusitis | | | |
| Shortness of breath | | | | Frequent or sever headache | | | | Easy fatigability | | | | Severe menstrual cramps | | | |
| Asthma | | | | Dizziness or fainting spells | | | | Anemia or Sickle Cell Anemia | | | | Irregular periods | | | |
| Pneumonia | | | | Serious head injury | | | | Eye trouble besides need glasses | | | | Sexually transmitted | | | |
| Chronic cough | | | | Paralysis | | | | Bone, joint, or other deformity | | | | Blood transfusion | | | |
| Head or neck radiation treatments | | | | Disabling depression | | | | Knee problems | | | | Alcohol use | | | |
| Tumor or Cancer (specify) | | | | Excessive worry or anxiety | | | | Recurrent back pain | | | | Drug use | | | |
| Malaria | | | | Ulcer (duodenal or stomach) | | | | Neck injury | | | | Anorexia/Bulimia | | | |
| Thyroid trouble | | | | Intestina trouble | | | | Back injury | | | | Smoke 1+ pack cigarettes/week | | | |
| Diabetes | | | | Pilonidal cyst | | | | Broken bone (specify) | | | | Regularly exercise | | | |
| Serious skin disease | | | | Frequent vomiting | | | | Kidney infection | | | | Wear seat belt | | | |
| Mononucleosis | | | | Gall bladder | | | | Bladder infection | | | | Other (specify) | | | |

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 _____ 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.