FAYETTEVILLE STATE UNIVERSITY
STUDENT HEALTH SERVICES
A DIVISION OF STUDENT AFFAIRS
1200 Murchison Road—Spaulding Building
Fayetteville, NC 28301
Office: (910) 672-1259 Fax: (910) 672-1366

NORTH CAROLINA REQUIRED IMMUNIZATION RECORD & MEDICAL HISTORY FORM

Welcome to Fayetteville State University Student Health Service!!
Student Health Service's MISSION is to provide quality health care for students enrolled at Fayetteville State University. Student Health Service (SHS) provides reasonable patient Healthcare for minor illnesses and injuries. We look forward to serving you.
If you have any questions regarding this form, please call 910-672-1259.

IMPORTANT !! DEADLINE JUNE 1st

Return your form by June 1st if you are entering school for Fall semester. If you are entering Fayetteville State University for Spring or Summer sessions, or in case of late acceptance, you must submit this form within 10 days of your acceptance notification. Please return any attached copies of immunization records in the same envelope. All forms must be sent directly to Student Health Services.

Avoid Registration Cancellations by Returning this FORM!

All new, transfer, and readmitted FSU students (who have NOT attended FSU in the past two years) MUST complete this form.

Include your name and/or FSU Personal ID# (Banner #) on all attachments.

FSU Student Insurance Plan

All registered students are required to enroll in this insurance plan unless proof of comparable coverage is furnished online only at studentbluenc.com/fsu. Insurance Premium will appear on the Covered Student's tuition bill. Online, home study, and television courses do not fulfill the eligibility requirements.
Information regarding FSU Student Insurance Plan may be obtained by calling 910-672-1259 or 910-672-2121.

North Carolina General Statue

North Carolina State Law
(General Statue 130A 152-157) requires that all students entering college present a certificate of immunization, which documents that the student has received the immunizations required by law. Under this law, **REGISTRATION WILL BE CANCELLED AND THE STUDENT ACADEMICALLY WITHDRAWN 30 days after classes** begin if the Immunization Documentation and Medical History forms have not been received by Student Health Services (SHS).

- Please obtain all needed immunizations **BEFORE** submitting the form. Required immunizations are available at local health departments.
- **KEEP COPY OF ALL IMMUNIZATION RECORDS FOR YOUR PERSONAL FILES.**
- You will be informed of any missing information.

Some PROGRAMS may require their department to receive additional immunizations. Contact your department for specifications. If the Varicella immunization is required, complete SECTION B of the IMMUNIZATION FORM. Copies of immunization records or blood titers are acceptable of both.

NOTE: Some departments may require a copy of this Medical History form. IT IS YOUR RESPONSIBILITY TO PROVIDE YOUR PROGRAM WITH A COPY.

"To serve OUR STUDENTS"

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 and 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/year)	*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 _________
15ft. 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 a loss or seriously impaired function of any paired organs? Yes _______ No _________
Explain ____

B. Is the 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 ______________________, he/she appears able to participate in the activities of a health profession in a clinical setting. Yes___ No ___ If no, 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 ______

*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.

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

LAST NAME (print) FIRST NAME MIDDLE NAME FSU Student ID Number *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 EMAIL________________

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

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

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON TO CONTACT IN CASE OF 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 of 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 abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need 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 stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted			
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, 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.

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.)

______________________________ ______________________

Student Name (print) **FSU Student ID Number**

______________________________ ______________________

Signature of Student **Date**

______________________________ ______________________

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

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.

Your Immunizations may be obtained from any of the following:

- High School Records – Although not official, 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 REQUIREMENTS (For further information: http://www.immunizenc.com/college.htm)

Diphtheria, Tetanus and/or Pertussis[1]	Polio[2]	Measles[3]	Mumps[4]	Rubella[5]	Hepatitis B[6]
3	3	2	2	1	3

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 **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 with 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 [3] – 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 [4] – 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 [5] – 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**.

FOOTNOTE [6] – Hepatitis B vaccine is not required if any of the following occur: Born before July 1, 1994.

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 and read at an appropriate medical facility within the 12 months prior to the first day of class. (Chest x-ray required if test is positive).

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. 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.

FAYETTEVILLE STATE UNIVERSITY - IMMUNIZATION RECORD

Last Name	First Name	Middle	Date of Birth (MM/DD/YYYY)	Personal ID# (PID)

SECTION A REQUIRED IMMUNIZATIONS

All students must submit documentation of 3 DTP, Td or Tdap vaccines regardless of age. One MUST be a Tdap.

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
DTaP/DTP/Td (Diphtheria/Tetanus/Pertussis or Tetanus/Diphtheria Toxoid)				
Tdap booster (All Students MUST show proof of a Tdap booster)				
Polio (3 doses, only required if 17 years of age or younger)				
MMR (Measles, Mumps, Rubella -- 2 MMR vaccines required on or after first birthday OR 2 Measles, 2 Mumps and 1 Rubella single doses OR positive Measles, Mumps, Rubella titers)				
Measles (2 required on or after first birthday OR positive titer OR documented disease date)			Disease Date	**Titer Date & Result
Mumps (2 required on or after first birthday OR positive titer)			(Disease Date NOT Accepted)	**Titer Date & Result
Rubella (1 required on or after first birthday OR positive titer)			(Disease Date NOT Accepted)	**Titer Date & Result
Hepatitis B Series (only required if born after July 1, 1994)				**Titer NOT Accepted for required Hep B Series**

SECTION B RECOMMENDED IMMUNIZATIONS

Immunization Name		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Has the student received the Meningococcal vaccine (Menactra, Menveo, Menomune, MPSV4, MCV4)? ☐ Yes ☐ No					
If **Yes**, date(s) received - **Booster dose recommended at age 16**					
Meningococcal B vaccine (Bexsero or Trumenba - Please discuss risks and benefits of this vaccine with your medical provider)					
Hepatitis A					
Hepatitis A/B combination series					
Pneumococcal					
Human Papillomavirus (HPV)	Cervarix				
	Gardasil				
	Gardasil-9				
Varicella (2 doses, documentation of disease date or positive titer)				Disease Date	**Titer Date & Result
Tuberculin Skin Test (TST)	Date Read				
	mm induration	mm	mm	mm	mm
	Date of IGRA (QuantiFERON or T-SPOT) test			**Chest X-ray Date	
	Result of IGRA test	Positive Negative	Positive Negative	**Chest X-ray Result	Positive Negative

** Must attach a copy of all laboratory and Chest X-ray results

Signature and Credentials of Health Care Provider ______ **Date** ______

Printed Name and Credentials of Health Care Provider ______ **Area Code/Phone Number** ______

Office Address ______ **City** ______ **State** ______ **Zip Code** ______