

**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	North Carolina General Statute
<p>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.</p>	<p style="text-align: center;"><u>North Carolina State Law</u></p> <p>(General Statute 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 Under this law, REGISTRATION WILL BE CANCELLED AND THE STUDENT ACADEMICALLY WITHDRAWN 30 days after classes begin if the Immunization Documentation and Medical History forms have not been received by Student Health Services (SHS).</p>
Avoid Registration Cancellations by Returning this FORM!	<ul style="list-style-type: none"> • 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.
<p>All new, transfer, and readmitted FSU students (who have NOT attended FSU in the past two years) MUST complete this form.</p>	<p>Some departments may require their students to receive additional immunizations. Contact your department for requirements. Copies of immunization records or blood titers are acceptable.</p>
<p style="text-align: center;">Include your name and FSU Banner ID Number on all attachments.</p>	<p>NOTE: Some departments may require a copy of this Medical History form. IT IS YOUR RESPONSIBILITY TO PROVIDE YOUR PROGRAM WITH A COPY.</p>
<p style="text-align: center;">FSU Student Insurance Plan</p> <p>All registered students are required to enroll in this insurance plan unless proof of comparable coverage is furnished online only at www.bcbsnc.com/fsu. Insurance Premium will appear on the 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.</p>	

“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)		FSU Banner ID Number

Permanent Address	City	State	Zip Code	Area Code/Phone Number
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Height _____ Weight _____ TPR _____ / _____ / _____ BP _____ / _____

<p>IF REQUIRED: Vision: Corrected Right 20/ _____ Left 20/ _____ Uncorrected Right 20/ _____ Left 20/ _____ Color Vision _____ Hearing: (gross) Right _____ Left _____ 15ft. Right _____ Left _____</p>	<p>IF REQUIRED: Urinalysis: Sugar: _____ Albumin _____ Micro _____ Hgb or Hct (if indicated) _____ STS (may be required by some departments) Date _____ Results _____ Recommendations _____</p>
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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 Banner ID Number _____ *SSN Number (Last Four Only) _____

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 <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATES _____	SEMESTER ENTERING (circle): FALL SPRING SUMMER 1 SUMMER 2 OTHER YEAR 20_____
	PREVIOUSLY ENROLLED HERE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATES _____	

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) _____	AREA CODE/TELEPHONE NUMBER _____
NAME OF POLICY HOLDER _____ *SSN Number (Last Four) _____	EMPLOYER _____
POLICY OR CERTIFICATE NUMBER _____ GROUP NUMBER _____	IS THIS AN HMO/PPO/MANAGED CARE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO

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		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol or blood fat disorder				Cancer (type):			
Stroke				Diabetes				Alcohol/drug problems			
Heart attack before age 55				Glaucoma				Psychiatric illness			
Blood or clotting disorder								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		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 severe headache				Easy fatigability				Severe menstrual cramps			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia Circle				Irregular periods			
Pneumonia				Severe 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 Problems				Intestinal 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 Problem				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.

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 Banner 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 FSU Banner 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.

Last Name	First Name	Middle Name	Date of Birth
			FSU Banner ID Number

Please print in black ink. To be completed and signed by physician or clinic. A complete official immunization record from a physician or clinic may be attached to this form. **Student to confirm identifying information above is complete before submission.**

SECTION A Required Immunizations	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 after 7/2008)				
* Td booster				
* Polio				
* MMR (after first birthday)				
* Measles/ Rubella (MR) (after first birthday)				
* Measles (after first birthday)				MUST SUBMIT LABORATORY REPORT FOR ALL TITERS
* Mumps				
* Rubella				
* Hepatitis B series (if born on or after July 1, 1994)				

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	mo/day/year
* Hepatitis A				
* Varicella (chicken pox) series of two				
* Haemophilus influenzae type b				
* Pneumococcal				
* Hepatitis A series only				
* HPV (Gardasil)				
* Tuberculin Skin Test (PPD) Date read				
(within 12 months) Report result in mm induration				
Chest X-Ray, if positive PPD Date				
Results				
Treatment if applicable Date				
* 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 measles, rubella, mumps, and varicella is acceptable if the vaccine is not taken. History of disease, even from a physician, is not acceptable.