

Dear Student,

Thank you for choosing Fayetteville State University for your educational journey. This document will explain the **steps regarding uploading your immunization records, electronically submitting your medical health documentation, and the waive / enroll process.**

Student Health Services adheres to the statutes set by the North Carolina Department of Health and Human Services (NC DHHS). North Carolina State Law (General Statute 130A 152-157) requires eligible students (undergraduate and graduate) to present proof of immunizations prior to registration to protect you and others while you are at the university. Under North Carolina regulations, a student may be dropped from classes **for non-compliance.**

## Step # 1 Immunization Requirements

Students 18 years of age or older ..... You may be missing the following Immunization requirements please check your Patient Portal at <https://uncfsu.medicatconnect.com/>.

- \* Tetanus (DTP, DTap, Td, Tdap) – 3 doses are required of which one must have been within the past 10 years
- \* MMR (Measles, Mumps, Rubella) – 2 doses are required
- \* Hepatitis B (Hep B) – 3 doses are required for students **born on or after July 1, 1994**
- \* Polio (OPV, IPV) – 3 doses are required for students **under age 18**
- \* Varicella (VAR) – 2 doses are required for students **born on or after April 1, 2001**
- \* Meningococcal Vaccine – 2 doses are required for students born on or after January 1, 2003 **(residing in the residence hall)**
- \* TB skin test (PPD or TST) or QuantiFERON-TB Gold Plus – **are required for International Students ONLY** (Students with a Green Card or Born on USA Military Base are exempt).

Please follow the steps below to submit your immunization information.

### Next Step "1A": Log In

You may login to Patient Portal at <https://uncfsu.medicatconnect.com/> by using your FSU E-mail credentials.

### Next Step "1B": Upload

We are required by law to have a copy of your immunization record. The record must have a health care provider's name and address and/or clinic stamp with the clinic's address. Upload your Immunization record under the "Upload" tab.

### **Accepted Forms of Immunization Documentation Include:**

- Government or Health Department issued Personal Immunization Record
- High School Transcript or College/University Record
- Military Record with clinic stamp that includes the clinic's address
- Physician/Clinic Office Record with a clinic stamp that includes the clinic's address
- NC Immunization Registry or Other State Immunization Registry Records
- American Academy of Pediatrics Immunization Form with a clinic stamp that includes the clinic's address
- World Health Organization International Certificate of Vaccination

First, create image files of your completed Immunization Verification Form and other related documents. Here are some steps that may help you do this:

- Take a picture of the completed Immunization Verification Form with a camera or mobile device camera, making sure that the picture is legible. Save the images to your computer if completing the process by computer. If completing on your mobile device, you can use images directly from the device. Please be sure to only upload images of the Immunization Verification Form and related documents as these images become a permanent part of your medical record.
- Another option is to scan your Immunization Verification Form and related documents to your computer. You must be sure to save the files as an image file such as jpg, jpeg, png, gif and make sure the file size is under 4MB.

Next Step "1C": Enter Vaccination Dates

Enter your vaccination dates in the immunization section by clicking on the "Immunization" tab.

- Go to the bottom of the page to the "Required and Recommended" sections.
- Key in each date for the immunization showing on your documentation.
- Once you are finished entering your vaccination dates, please click the "Submit" button in the bottom right corner.

## Step # 2 Complete the following Fillable Forms

Please log in to the Student Patient Portal <https://uncfsu.medicatconnect.com/> to upload and complete the required health information. You may also scan this QR code.

- a) Consent for Treatment
- b) FSU SHS COVID Agreement
- c) New Health History Form
- d) Note of Privacy Practices FSU
- e) Texting Opt-in / Opt- Out



Once immunization records have been verified by SHS Staff, the status on the "Immunization" screen will change from "Not Compliant" to "Compliant." Since school has started, any communication from the Student Health Services' immunization department will be in the form of an email / or secure messaging via the Patient Portal directly to the student.

We look forward to having you as a student and serving you at Student Health Services.

**PLEASE CHECK YOUR PATIENT PORTAL TO MAKE SURE YOU HAVE  
COMPLETED ALL THE STEPS**

## Step # 3 Student Blue Enroll / Waive

To waive / enroll in the Student Health Insurance Plan, students must complete the online process at <http://studentbluenc.com/#/fsu>. Deadline to waive /enroll is for the Fall September 10 and Spring February 1.

# GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

**IMPORTANT** – The immunization requirements must be met for enrollment at the University. Failure to comply will result in withdrawal from classes without credit. These records are due at the time of admission.

Be certain that your Name, Date of Birth, and ID Number appear on each sheet. Records must be written in English with the dates of vaccine administration including the month, day, and the year.

**Acceptable Records of your Immunizations may be obtained from any of the following:**

- 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) - 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:

| VACCINE<br>REQUIRED<br><small>(REVIEW ALL FOOTNOTES BELOW)</small> | Tetanus,<br>Diphtheria,<br>and Pertussis<br>(Tdap) <sup>1</sup> | Diphtheria,<br>Tetanus,<br>and/or<br>Pertussis <sup>1</sup> | Polio <sup>2</sup> | Measles <sup>3</sup> | Mumps <sup>4</sup> | Rubella <sup>5</sup> | Hepatitis B <sup>6</sup> | Varicella <sup>7</sup> |
|--|---|---|--------------------|----------------------|--------------------|----------------------|--------------------------|------------------------|
| DOSES REQUIRED   | <b>1</b>  | <b>2</b>  | <b>3</b>           | <b>2</b>             | <b>2</b>           | <b>1</b>             | <b>3</b>                 | <b>1</b>               |

**FOOTNOTE<sup>1</sup>** – Three doses are required for students entering college or university. Students entering college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid; one of which must be tetanus/diphtheria/pertussis (Tdap).

**FOOTNOTE<sup>2</sup>** – A student attending school who has attained his or her 18<sup>th</sup> birthday is not required to receive polio vaccine.

**FOOTNOTE<sup>3</sup>** – Measles vaccines are not required if any of the following occur: Documented physician diagnosis of disease prior to January 1, 1994; a student who has been documented by serological testing to have a protective antibody titer against measles and **submits the lab report**; or a student born prior to 1957. A student 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: A student who has been documented by serological testing to have a protective antibody titer against mumps and **submits the lab report**; a student born prior to 1957; or enrolled in college or university for the first time before July 1, 1994. A student 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, a student who has been documented by serological testing to have a protective antibody titer against rubella and **submits the lab report**.

**FOOTNOTE<sup>6</sup>** – Hepatitis B series is required for students born on or after July 1, 1994. Serological testing to document protective antibody titer against Hepatitis B is **not acceptable**. (Heplisav-B, A 2-dose series is acceptable for this requirement. This vaccine is currently available in the U.S. only)

**FOOTNOTE<sup>7</sup>** – Varicella vaccine is not required if any of the following occur: Documented physician diagnosis of disease, a student has been documented by serological testing to have a protective antibody titer against varicella and **submits the lab report**; or a student is born before April 1, 2001.

### INTERNATIONAL STUDENTS, STUDENTS WHO HAVE LIVED IN OR TRAVELED TO HIGH-RISK COUNTRIES/TERRITORIES

Vaccines are required as noted above. Additionally, these students are required to have a TB skin test (PPD or TST) or a TB blood test (T-spot, **QuantiFERON®** Gold Plus) that has been administered and read at an appropriate medical facility within 12 months prior to the first day of class. (Chest x-ray required if test is positive).

More information is available on the last page of this form.

## FAYETTEVILLE STATE UNIVERSITY – IMMUNIZATION RECORD

|  |  |  |   |  |   |
|--|--|--|---|--|---|
| Last Name  |  | First Name   | Middle Name                                 | Date of Birth  | Student ID #  |
| HAVE YOU PREVIOUSLY ENTERED A FOUR-YEAR COLLEGE/UNIVERSITY?  |  |  |   | NO   | If YES, when?   |
| Where did you previously attend a four-year college/university?  |  |  |   |  |   |
| Forms to be completed and signed by a physician or clinic  |  |  |   |  |   |
| <b>SECTION A: REQUIRED IMMUNIZATIONS</b>   |  |  | MM/DD/YY                                    | MM/DD/YY   | MM/DD/YY  |
| All Students must submit documentation of 3 DTP, DTaP, Td or Tdap vaccines regardless of age. One MUST be a Tdap |  |  |   |  |   |
| DTP/DTaP/Td  |  |  |   |  |   |
| Tdap booster   |  |  |   |  |   |
| Polio 3 doses (required if ≤ 17 years of age)  |  |  |   |  |   |
| Hepatitis B 3 doses (required if born on or after July 1, 1994)  |  |  |   |  | *Titer Date & Result submit lab report                              |
| Hepatitis B (Heplisav-B 2 doses: if ≥ 18 years of age, available in US only)                                     |  |  |   |  |   |
| MMR Series: <u>Measles</u> , <u>Mumps</u> , <u>Rubella</u> : (given <i>after</i> 1 <sup>st</sup> birthday)       |  |  |   |  |   |
| Measles 2 doses (given <i>after</i> 1 <sup>st</sup> birthday)  |  |  |   |  | Disease Date: *Titer Date & Result submit lab report                |
| Mumps 2 doses (given <i>after</i> 1 <sup>st</sup> birthday)  |  |  |   |  | Disease Date: NOT Acceptable *Titer Date & Result submit lab report |
| Rubella 1 dose (given <i>after</i> 1 <sup>st</sup> birthday)   |  |  |   |  | Disease Date: NOT Acceptable *Titer Date & Result submit lab report |
| Varicella (required if born on or after April 1, 2001)   |  |  |   |  | Disease Date: *Titer Date & Result submit lab report                |
| INTERNATIONAL STUDENTS/PRIOR RESIDENTS OF or RECENT TRAVEL TO HIGH RISK COUNTRIES/TERRITORIES                    |  |  |   |  |   |
| Tuberculosis Test must be completed within the past 12 months  |  |  |   |  |   |
| Tuberculin Skin Test (TST)   |  | Date Resulted  | Chest X-ray Required if TB Test is positive | Chest X-ray date:  |   |
| *Must submit skin test report  |  | mm induration  |   |  |   |
|  |  | mm   |   |  |   |
| IGRA (QuantiFERON or T-Spot) Test  |  | Date Resulted  | Chest X-ray Required if TB Test is positive | Chest X-ray result:  |   |
| *Recommended if history of BCG Vaccine   |  |  |   |  |   |
| *Must submit lab report  |  | <input type="checkbox"/> negative<br><input type="checkbox"/> positive |   | <input type="checkbox"/> negative<br><input type="checkbox"/> positive |   |
| *Must submit chest x-ray report if indicated   |  |  |   |  |   |
| <b>SECTION B: RECOMMENDED IMMUNIZATIONS</b>  |  |  | MM/DD/YY                                    | MM/DD/YY   | MM/DD/YY  |
| Meningococcal vaccine (MenACYW: Menactra, Menveo, Memomune, MenQuadfi, MPSV4)                                    |  |  |   |  |   |
| Meningococcal B Vaccine (Bexsero, Trumenba)  |  |  |   |  |   |
| Hepatitis A Vaccine  |  |  |   |  |   |
| Hepatitis A/B combined Vaccine (Twinrix)   |  |  |   |  |   |
| Pneumococcal Vaccine   |  |  |   |  |   |
| Human Papillomavirus/HPV (Cervarix, Gardasil, Gardasil 9)  |  |  |   |  |   |
| COVID-19 Vaccine (must submit vaccine card or other acceptable documentation)                                    |  |  |   |  |   |

\*Must attach a copy of the laboratory/CXR results

\*Signature or Clinic Stamp Required

Signature and Credentials of HealthCare Provider

Date

Print Name and Credentials of HealthCare Provider

Phone Number

Office Address

City

State

Zip Code



## PHYSICAL EXAMINATION FORM

Full Name: \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_ Sex: MALE or FEMALE  
 Address: \_\_\_\_\_ Phone number: \_\_\_\_\_  
 Banner: \_\_\_\_\_

**\*\*\*MEDICAL EVALUATION: TO BE COMPLETED ONLY BY MEDICAL PERSONNEL\*\*\***

**MEDICAL HISTORY:**

Drug Allergies: \_\_\_\_\_ Current Medications: \_\_\_\_\_ LMP: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_ Resting HR: \_\_\_\_\_ Respiratory Rate: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected Y N Hearing: Right \_\_\_\_\_ Left: \_\_\_\_\_ Not Assessed \_\_\_\_\_  
 Date of Assessment: \_\_\_\_\_

|  | Denies | Admits, explain |
|--|--------|-----------------|
| Any known medical conditions   |        |                 |
| Any recent illnesses or injuries   |        |                 |
| Any history of hospitalizations or surgeries   |        |                 |
| Any history of chest pain, shortness of breath, lightheadedness or passing out during or after working out |        |                 |
| Any recent history of being restricted from participating in work, classroom or physical activity          |        |                 |

**PHYSICAL EXAM:**

| System  | Normal | Abnormal Findings (attach additional documentation if needed) |
|---|--------|---|
| Appearance (WDWN, NAD)  |        |   |
| HEENT (NCAT, PERRLA, EOMI, TMs clear, pharynx clear)                                      |        |   |
| Lymph nodes (no apparent adenopathy)  |        |   |
| Respiratory (CTAB, no wheezes/rales/rhonchi)  |        |   |
| Cardiovascular (RRR, w/o MRG)   |        |   |
| Pulses (equal bilaterally all extremities)  |        |   |
| Gastrointestinal (BS normal x 4, soft, NTND)  |        |   |
| Genitourinary (no hernia, no abnormal findings)   |        |   |
| Musculoskeletal (Full ROM, equal strength)  |        |   |
| Metabolic/Endocrine (no thyromegaly, acanthosis, goiter, gynecomastia, skin changes, etc) |        |   |
| Mammary (no lumps, rashes, galactorrhea)  |        |   |
| Skin (no rashes or lesions on exposed area)   |        |   |
| Neuro (CN II-XII grossly intact, gait normal)   |        |   |
| Psych (A&O x 3, mood appropriate)   |        |   |

**CLEARANCE**

- Is there a loss or seriously impaired function of any organs? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
 a. Explain: \_\_\_\_\_
- Is the student under treatment for any medical or emotional condition? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
 a. Are these conditions controlled at this time? Yes: \_\_\_\_\_ No: \_\_\_\_\_  
 b. Explain: \_\_\_\_\_
- Recommendation for physical activity (physical education, intramurals, etc) Unlimited \_\_\_\_\_ Limited \_\_\_\_\_  
 a. Explain: \_\_\_\_\_
- Is the student physically and emotionally healthy to attend a collegiate level academic program? Yes \_\_\_\_\_ No \_\_\_\_\_  
 a. Explain: \_\_\_\_\_

Physician/Physician Assistant/Nurse Practitioner Signature

Physician/Physician Assistant/Nurse Practitioner Printed Name

Date:

**OFFICE STAMP OR ADDRESS AND PHONE NUMBER:**

## MENINGOCOCCAL VACCINE WAIVER FORM

The Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC) recommends that first-year college students living in residence halls should receive at least one (1) dose of meningococcal conjugate vaccine before college entry. All students who will be living in campus housing and who are age 23 or younger must submit proof of one (1) dose of meningococcal conjugate vaccine.

Fayetteville State University requires that every student residing in a Housing & Residence Life facility has received a one-time vaccination against meningococcal disease or has signed a waiver. This waiver will detail information on the risks associated with meningococcal disease, the availability, and the effectiveness of vaccine, and that they choose not to be vaccinated for religious or other reasons. Please read below and complete **ONE OF THE TWO** sections below, as it pertains to you.

## MENINGOCOCCAL VACCINE REQUIREMENT

I have received the meningococcal vaccine as required by Fayetteville State University Housing & Residence Life for individuals residing in University Housing. Documentation from a physician or health clinic or receipt of vaccine, and date vaccine was administered is has been upload into SHS Patient Portal.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Bronco ID #

\_\_\_\_\_  
Age

## WAIVER AGE 18 YEARS OR OLDER

I am 18 years of age or older. I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of meningococcal vaccine. I understand that meningococcal disease is a rare but life-threatening illness. I understand that Fayetteville State University requires that an individual enrolled in an institute of higher education in North Carolina who resides in University Housing shall receive vaccination against meningococcal disease unless the individual signs the waiver to the vaccination.

I voluntarily agree to release, discharge, indemnify, and hold harmless FSU from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the Universities requirements. I choose to waive receipt of the meningococcal vaccine.

### Risks and Benefits of Meningococcal Vaccination

| <i>Vaccine-Preventable Disease</i>   | <i>Effectiveness of Vaccine</i>   | <i>Possible Side Effects of Vaccination</i>  |
|--|---|--|
| Meningococcal disease is an acute, potentially severe illness that most often causes meningitis, an infection of the spinal fluid and the fluid that surrounds the brain. It leads to sudden onset of fever, headache, and stiff neck and is usually accompanied by nausea, vomiting, light sensitivity, and altered mental status. Less commonly, it can cause pneumonia, arthritis, and ear/throat infections. Meningococcal disease can result in hearing loss, nervous system problems, seizures, strokes, loss of limbs (arms, legs), and even death. | A protective level of antibody is usually achieved within 7 – 10 days of vaccination. The vaccines protect about 90% of individuals who get them. | The most common side effects are redness or pain at the injection site lasting 1– 2 days, headache, and fatigue. Serious allergic reactions are very rare. |

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Bronco ID #

\_\_\_\_\_  
Age