**MAIL TO: Chowan University Student Health Services • One University Place, Murfreesboro, NC 27855**

 **REPORT OF MEDICAL HISTORY (**Please type or print in black ink**) TO BE COMPLETED BY STUDENT**

 LAST NAME (PRINT) FIRST NAME MIDDLE NAME \*SOCIAL SECURITY NO.

 PERMANENT ADDRESS CITY STATE ZIP PHONE WITH AREA CODE

 DATE OF BIRTH (MO/DAY/YR)

GENDER ❑ M ❑ F MARITAL STATUS ❑ S ❑ M ❑ OTHER

PREVIOUSLY ENROLLED HERE ❑ YES ❑ NO

SEMESTER ENTERING (CIRCLE): FALL SPRING SUMMER OTHER YEAR

 HEALTH INSURANCE (NAME & ADDRESS OF COMPANY) **\*\*ATTACH COPY OF CARD\*\*** TELEPHONE

 NAME OF POLICY HOLDER \*SOCIAL SECURITY NO. 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 AN EMERGENCY RELATIONSHIP

 ADDRESS AREA CODE/PHONE

 The following health history is confidential and does not affect your admission status. In the event of an emergency situation or by court order, this info

 will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

 **FAMILY & PERSONAL HEALTH HISTORY (Please type or print in black ink)**

 Has any person, related by blood, had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Relationship |
| Blood or clotting disorder |  |  |  |
| Alcohol/drug problems |  |  |  |
| Psychiatric illness |  |  |  |
| Suicide |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Relationship |
| High blood pressure |  |  |  |
| Stroke |  |  |  |
| Cancer type:  |  |  |  |
| Heart attack before age 55 |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Relationship |
| Cholesterol or blood fat disorder |  |  |  |
| Diabetes |  |  |  |
| Glaucoma |  |  |  |

 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 |
| Self-induced vomiting |  |  |  |
| Frequent vomiting |  |  |  |
| Gall bladder trouble/gallstones |  |  |  |
| 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 |  |  |  |
| Shoulder dislocation |  |  |  |
| Knee problems |  |  |  |
| Recurrent back pain |  |  |  |
| Neck injury |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| Back injury |  |  |  |
| Broken bones |  |  |  |
| Kidney infection |  |  |  |
| Kidney stone |  |  |  |
| Protein or blood in urine |  |  |  |
| Hearing loss |  |  |  |
| Sinusitis |  |  |  |
| Severe menstrual cramps |  |  |  |
| Irregular periods |  |  |  |
| Blood transfusion |  |  |  |
| Smoke 1 + pack cigarettes/week |  |  |  |
| Diabetes |  |  |  |
| Anorexia/Bulimia |  |  |  |
| Allergy injection therapy |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| Mononucleosis |  |  |  |
| Hay fever |  |  |  |
| Head or neck radiation treatments |  |  |  |
| Arthritis |  |  |  |
| Concussion |  |  |  |
| Frequent or severe headache |  |  |  |
| Dizziness or fainting spells |  |  |  |
| Severe head injury |  |  |  |
| Paralysis |  |  |  |
| Epilepsy/seizures |  |  |  |
| Disabling depression |  |  |  |
| Excessive worry or anxiety |  |  |  |
| Ulcer (duodenal or stomach) |  |  |  |
| Intestinal trouble |  |  |  |
| Pilonidal cyst |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Year |
| High blood pressure |  |  |  |
| Rheumatic fever |  |  |  |
| Heart trouble |  |  |  |
| Pain or pressure in chest |  |  |  |
| Shortness of breath |  |  |  |
| Asthma |  |  |  |
| Pneumonia |  |  |  |
| Chronic cough |  |  |  |
| Tuberculosis |  |  |  |
| Tumor or cancer (specify) |  |  |  |
| Malaria |  |  |  |
| Thyroid trouble |  |  |  |
| Serious skin disease |  |  |  |
| Alcohol/drug use |  |  |  |
| Sexually transmitted disease |  |  |  |

 Please describe any conditions or disabilities that would exclude participation in physical education. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you exercise three or four times per week? Yes No Do you use a seat belt on a regular basis? Yes No

 Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*Prevision of Social Security number is voluntary and solely requested for admin convenience, record keeping accuracy.

 **FAMILY & PERSONAL HEALTH HISTORY CONTINUED….. (Please type or print in black ink)**

 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.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Explanation** |
| Penicillin |  |  |  |
| Sulfa |  |  |  |
| Other antibiotics (name) |  |  |  |
| Aspirin |  |  |  |
| Codeine or other pain relievers |  |  |  |
| Other drugs, medicines, chemicals(specify) |  |  |  |
| Insect bites |  |  |  |
| Food allergies (name) |  |  |  |
|  | **Yes** | **No** | **Explanation** |
| Have you ever been a patient inany type hospital or psychiatric ER? (When, where, why) |  |  |  |
| Have you ever been depressed for weeks, lost interest in activities, trouble concen-trating, or thought about killing yourself? |  |  |  |
| Has your academic career been inter- rupted due to physical or emotional problems? (Please explain.) |  |  |  |
| Is there loss or seriously impaired function of any paired organs? (Please describe.) |  |  |  |
| Other than for a 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 injury 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 under- stand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student Health Service to release information from my (son/daughter’s) medical record to a physician, hospital, or other medical agency 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.

(C) I am aware that the Student Health Service charges for some services and I may be billed through the Business Office of Chowan University. I accept personal responsibility for settling the account with the university and for payment of incurred charges. Chowan University does not file medical insurance.

Signature of Student Date

Signature of Parent/Guardian if under age 18 Date

 **GUIDELINES FOR COMPLETING IMMUNIZATION RECORD**

**IMPORTANT**

* **The Immunization Record form must be completed.**
* Records must include a physician’s signature, health department stamp, or high school record attachment.
* Records must be documented in black INK and all corrections must be signed.
* All dates must include **month, day and year** of administration.
* Your immunization records may be obtained from your high school, physician, health department, military record, or previously attended college.
* These records may not fulfill all requirements as listed below. It is your responsibility to assure compliance with required immunizations.
* Students that do not provide documentation of immunizations are subject to dismissal as required by the state of North Carolina.

 **S E CTION A...** Immunizations that are **REQUIRED** pursuant to NC state law and institutional policy.

**Diphtheria, Tetanus and Pertussis …………………………………………….. REQUIRED**

* **Three doses** are required for individuals entering college or university.
* Individuals 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.

**Polio ……………….……………………………………………………………….... REQUIRED**

* **Three doses** are required for individuals entering college or university.
* An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

**Measles …………………………………………………………………………...…. REQUIRED**

* **Two doses** at least 28 days apart are required for individuals entering college or university.
* The requirement for a second dose does not apply to individuals who entered school, college or

university for the first time before July 1, 1994.

* A person who has been diagnosed prior to January 1, 1994, by a physician (or designee such

as a nurse practitioner or physician’s assistant) as having measles (rubeola) or an individual who

has been documented by serological testing to have a protective antibody titer against measles

is not required to receive measles vaccine.

* Individuals born before 1957 are not required to receive measles vaccine except in measles outbreak situations.

**Mumps ………………………………………………………………………………... REQUIRED**

* **Two doses** are required for individuals entering college or university. A physician's diagnosis is not acceptable for mumps disease(s). Individuals must be immunized or have laboratory confirmation of disease or have been documented by serological testing to have a protective antibody against mumps.
* Individuals born before 1957 are not required to receive the mumps vaccine.
* Individuals that entered college or university before July 1, 1994, are not required to receive the vaccine.
* Individuals that entered school, college, or university before July 1, 2008, are not required to receive the second dose of mumps vaccine.

Continued on backside

**S E CTION A CONTENUED...**

**Rubella ………………………………………………………………………………... REQUIRED**

* **One dose** is required for individuals entering college or university. A physician's diagnosis is not

acceptable for rubella disease(s). Individuals must be immunized or have laboratory confirmation

of rubella disease or have been documented by serological testing to have a protective antibody

titer against rubella.

* Any individual who has attained his or her fiftieth birthday is not required to receive rubella vaccine

except in outbreak situations.

* Any individual who entered college or university after his or her thirtieth birthday and before

February 1, 1989, is not required to receive rubella vaccine except in outbreak situations.

 **Hepatitis B …………………………………………………………………………..... REQUIRED**

* **Three doses** are required for individuals entering college or university.
* Hepatitis B vaccine is not required if an individual was born before July 1, 1994.

 **Varicella ……………………………………………………………………………….. REQUIRED**

* **One dose** is required for individuals entering college or university that were born on or after April 1, 2001.
* An individual who has laboratory confirmation of varicella disease immunity or has been documented by serological testing to have a protective antibody titer against varicella, or who has documentation from a physician, nurse practitioner, or physicians' assistant verifying history of varicella disease is not required to receive varicella vaccine. The documentation shall include the name of the individual with a history of varicella disease, the approximate date or age of infection, and a healthcare provider signature.
* Individuals born before April 1, 2001, are not required to receive varicella vaccine.

**Meningococcal………………………………………………………………………………. REQUIRED**

* **Two doses**.
* One dose is required for individuals entering the seventh grade or by 12 years of age, whichever comes first on or after July 1, 2015.
* A booster dose is required for individuals entering the 12th grade or by 17 years of age, whichever comes first.
* Individuals who entered seventh grade before July 1, 2015 are not required to receive the first dose.
* The booster dose does not apply to individuals who entered the 12th grade before August 1, 2020. If the first dose is administered on or after the 16th birthday, a booster dose is not required.
* Individuals born before January 1, 2003, shall not be required to receive meningococcal conjugate vaccine.

**NOTE...**

* In the event that the student’s immunization records cannot be obtained, a Titer Test may be submitted. The Titer Test must show confirmation that the student has a protective antibody against Measles, Mumps, Rubella, and Varicella. Laboratory test results must be attached.
* The student is still responsible for receiving the remaining immunizations required and turning the official records in to Student Health Services.

**IMMUNIZATION RECORD** (Please type or print in black ink)  **TO BE COMPLETED & SIGNED BY PHYSICIAN/ CLINIC**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| LAST NAME FIRST NAME MIDDLE NAME | DATE OF BIRTH (mo/day/year) | SOCIAL SECURITY NUMBER |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **SECTION A… STATE REQUIRED IMMUNIZATIONS** | #1 mo/day/year | #2 mo/day/year | #3 mo/day/year | #4 mo/day/year |
| • DTP or Td |  |  |  |  |
| • Polio |  |  |  |  |
| • MMR (after first birthday) |  |  |  |  |
| • Measles (after first birthday) |  |  | Disease Date | \*\*Titer Date & Result |
| • Mumps |  |  | (Disease DateNOT Accepted) | \*\*Titer Date & Result |
| • Rubella |  |  | (Disease DateNOT Accepted) | \*\*Titer Date & Result |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| • Hepatitis B series |  |  |  | \*\*Titer Date & Result |
| • Varicella (chicken pox) series of at least one dose or immunity by positive blood titer |  |  | Disease Date | \*\*Titer Date & Result |
| * Meningococcal
 |  |  |  |  |

 \*\* Attach Any Titer Lab Report

**Signature or Clinic Stamp REQUIRED:**

Signature of Physician/Physician Assistant/Nurse Practitioner Date

Print Name of Physician/Physician Assistant/Nurse Practitioner Area Code/Phone Number

Office Address

\* You may request a copy of your medical records while at Chowan University free of charge.

But after leaving the University the cost will be $5.00.

Records of former students are available for up to three years after leaving the university.

**PHYSICAL EXAMINATION** (Please type or print in black ink)

**TO BE COMPLETED & SIGNED BY PHYSICIAN/ 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 /

Vision: Corrected Right 20/ Uncorrected Right 20/

Left 20/ Left 20/ Urinalysis:

Sugar MicroAlbumin

Color Vision Hearing: (gross) Right Left

15 ft. Right Left

Hgb or Hct(if indicated)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STS (may be required by some departments)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Results

Recommendations

|  |  |  |  |
| --- | --- | --- | --- |
| Are there abnormalities? If so, describe fully | YES | NO | 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 loss or seriously impaired function of any paired organs? Yes

No

Explain

 B. Is student under treatment for any medical or emotional condition? Yes

No

Explain

 C. Recommendations for physical activity (physical education, intramurals, etc.) Unlimited

Limited

Explain

 D. Is student physically and emotionally healthy? Yes

No

Explain

Signature of Physician/Physician Assistant/Nurse Practitioner Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Office Address Area Code Phone Number

\*Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy.