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
High blood pressure			
Stroke			
Cancer type:			
Heart attack before age 55			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Blood or clotting disorder			
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			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Tuberculosis			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Serious skin disease			
Alcohol/drug use			
Sexually transmitted disease			

	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
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			

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 in any type hospital or psychiatric ER? (When, where, why)			
Have you ever been depressed for weeks, lost interest in activities, trouble concentrating, or thought about killing yourself?			
Has your academic career been inter- rupted due to physical or emotional problems? (Please			
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 understand 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.

SECTION 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.

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SECTION 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 Date NOT Accepted)	**Titer Date & Result
• Rubella			(Disease Date NOT 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/____ Left 20/____
Uncorrected Right 20/____ Left 20/____

Color Vision _____

Hearing: (gross) Right _____ Left _____
15 ft. Right _____ Left _____

Urinalysis: Sugar _____ Albumin ____
Micro _____

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.