



THE UNIVERSITY OF NORTH CAROLINA

GREENSBORO

Anna M. Gove Student Health Services
Attn: Immunizations Office
Greensboro, NC 27402-6170
Office: 336-334-4086
Fax: 336-334-5357

Welcome to the University of North Carolina Greensboro. The Student Medical Form is designed to collect information about your health history and current immunization status. Please complete and return this form **BEFORE** you arrive on campus.

You should make and keep a copy of your Student Medical Form for future reference.

Do I need to complete the attached Student Medical Form?

YES. All enrolled students are **required** to complete the UNCG Student Medical Form. A **physical examination is not required** for UNCG students. If you have any questions, please consult Student Health Services at 336-334-5340.

Do I need to complete the immunization record?

YES. All students must complete the immunization record and mail it to Student Health Services prior to Spring or Fall enrollment unless you are exempt.

You are *EXEMPT* from the immunization requirements *IF* you are registered for:

1. Only four (4) credit hours or less and residing off campus
2. Only 800 level classes (or higher), only off campus courses, or only summer courses
3. Evening courses (4 pm or later) or weekend courses only

The Immunization Clinic, located in the Anna M. Gove Student Health Center, is open year round to administer needed immunizations at a nominal fee.

We hope your experience at UNCG is a healthy one!

NOTE: IMMUNIZATION REQUIREMENTS ARE MANDATORY UNDER STATE LAW (North Carolina General Statute 130A 152-157). IF IMMUNIZATION REQUIREMENTS ARE NOT MET, REGISTRATION FOR CLASSES WILL BE CANCELLED. REGISTRATION WILL NOT BE REINSTATED UNTIL IMMUNIZATION REQUIREMENTS ARE MET.

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IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (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 year. **Keep a copy for your records.**)

- High School Records – These may contain some, but not all of your immunization information. Contact Student Health for help, if needed.
- 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).
- Previous College or University –**Your immunization records do not transfer automatically. You must request a copy.**

SECTION A: IMMUNIZATION REQUIREMENTS ACCORDING TO AGE

STUDENTS 17 YEARS OF AGE AND YOUNGER

DTP or Td ¹	Polio	Measles ²	Mumps ⁴	Rubella ⁴
3	3	2	1	1

STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER

DTP or Td ¹	Polio	Measles ^{2,3}	Mumps ⁴	Rubella ⁴
3	0	2	1	1

STUDENTS BORN BEFORE 1957

DTP or Td ¹	Polio	Measles	Mumps	Rubella ⁴
3	0	0	0	1

STUDENTS 50 YEARS OF AGE AND OLDER

DTP or Td ¹	Polio	Measles	Mumps	Rubella
3	0	0	0	0

International Students

Vaccine Required

Vaccines are required according to age (refer to appropriate box). Additionally, International students are required to have a TB skin test and negative result within the 12 months preceding the first day of classes (chest x-ray required if test is positive).

1. DTP (*Diphtheria-Tetanus-Pertussis*), Td (*Tetanus-Diphtheria*): One Td booster within the last ten years.
2. Measles: One dose on or after 12 months of age; second at least 30 days later. Must repeat Rubeola (measles) vaccine if received prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.
3. Two measles doses if entering college for the first time after July 1, 1994.
4. One dose on or after 12 months of age. Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

SECTION B: These vaccines are **RECOMMENDED**. Some may be required by certain departments. Consult your college or department for specific requirements.

SECTION C: **These vaccines are OPTIONAL.**

STUDENT MEDICAL FORM (Please print in black ink) To be completed by student

LAST NAME (print) FIRST NAME MIDDLE NAME Student ID# (PID#)

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): PREVIOUSLY ENROLLED HERE YES NO SEMESTER ENTERING (circle): FALL SPRING
FR. SO. JR. SR. GRAD. PROF. IF YES, DATES SUMMER 1 SUMMER 2 OTHER YEAR 20_____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

NAME OF POLICY HOLDER 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		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		Yes	No	Year
High blood pressure				Hay fever				Jaundice or hepatitis				Kidney stone			
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				Irregular periods			
Pneumonia				Severe head injury				Eye trouble besides need glasses				Sexually transmitted disease			
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 trouble				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 trouble or gallstones				Bladder infection				Other (specify)			

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 _____
Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

STUDENT MEDICAL FORM 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 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 injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION....PLEASE READ AND COMPLETE

AFFIRMATION AND CONSENT 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 Student Health Services medical staff during the duration of my (son's/daughter's) attendance at UNCG.

(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.

Signature of Student

Date

Signature of Parent/Guardian, if student under age 18

Date

Meningococcal (Meningitis) Disease and Vaccine Information Sheet:

MENINGOCOCCAL DISEASE is a rare but potentially fatal bacterial infection caused most often by the bacterium *Neisseria meningitides*. Meningococcal Meningitis is an inflammation of the membranes surrounding the brain and spinal cord that can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death. Meningococcal bacteria are transmitted through the air via droplets of respiratory secretion, by oral contact with shared items, such as cigarettes or drinking glasses, by kissing, or by direct contact with an infected person. Although anyone can come in contact with the bacteria that cause meningococcal disease, data also indicates certain social behaviors, such as exposure to passive and active smoking, bar patronage, and excessive alcohol consumption, may put students at increased risk for the disease. Patients with respiratory infections, compromised immunity, those in close contact to a known case, and travelers to endemic areas of the world are also at increased risk.

SYMPTOMS usually associated with meningococcal disease include fever, severe headache, stiff neck, rash, nausea, vomiting, and lethargy, and may resemble the flu. Meningitis usually peaks in late winter and early spring and its flu-like symptoms make diagnosis difficult. The bacteria may be carried in the nose or throat without symptoms. Meningococcal may also cause other body infections instead of meningitis, such as septic arthritis, brain inflammation, and pneumonia. Because the disease progresses rapidly, often in as little as 12 hours, students are urged to seek medical care immediately if they experience two or more of these symptoms concurrently. **TREATMENT** with antibiotics should begin as soon as the diagnosis is considered.

VACCINATION is available to protect against four of the five most common strains of bacteria that cause meningitis in the United States -- types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students. The vaccine is 85% effective against these four groups and provides protection for approximately three to five years. This vaccine is available at Student Health Services for \$75. The current vaccine does not protect against the group B bacteria strain. The vaccine is very safe; adverse reactions are mild and infrequent, consisting primarily of redness and pain at the injection site lasting up to two days.

The Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommends that college students, particularly freshmen living in residence halls, be educated about meningitis and the benefits of vaccination. This recommendation is based on recent studies showing that college students living in residence halls, particularly freshmen, have a six-fold increased risk of contracting meningitis over other college students. The recommendation further states that information about the disease and vaccination is appropriate for other undergraduate students who also wish to reduce their risk for the disease. To learn more about meningitis and the vaccine, I encourage you to visit the CDC website at www.cdc.gov/ncidod/diseases/submenus/sub_meningitis.htm, consult your health care provider, or you may contact our Immunization Office by calling (336) 334-4086.