



**The University of North Carolina at Greensboro
Anna M. Gove Student Health Center
Student Health Services
Immunizations Office**

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336.334.5340 Phone
336.334.5357 Fax
immunize@uncg.edu



Welcome to the University of North Carolina at 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.

Students are exempt from immunizations if they do not live on campus and take any combination of the following:

1. Off-campus courses
2. Evening courses
3. Weekend courses
4. No more than four traditional day credit hours in on-campus courses

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.



Accredited by
Accreditation Association for Ambulatory Health Care, Inc.

GUIDELINES FOR COMPLETING THE 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IMPORTANT: The immunization requirements must be met or according to NC law, you will be withdrawn from classes without credit.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 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.

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

- **High School Records** – 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 or WHO (World Health Organization) Documents** – These records may not contain all of the required immunizations.
- **Previous College or University Records** – **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.html>)

VACCINE REQUIRED REVIEW ALL FOOTNOTES BELOW	Diphtheria, Tetanus, and/or Pertussis ¹	Polio ²	Measles ³	Mumps ⁴	Rubella ⁵	Hepatitis B ⁶
Doses Required	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 or 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 test that has been administered and read at an appropriate US medical facility within the 12 months prior to the first day of class. (Chest x-ray is required if test is positive).

SECTION B: RECOMMENDED VACCINES

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.

SECTION C: OPTIONAL VACCINES

These vaccines are optional.

IMMUNIZATION RECORD				
LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	STUDENT ID#

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	MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR	Submit Laboratory Report	
*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)			** Disease Date	Titer Date & Result		
*Mumps			Not Acceptable *** Disease Date	Titer Date & Result		
*Rubella			Not Acceptable *** Disease Date	Titer Date & Result		
*Hepatitis B (required if born 7/1/94 or after)	(#1)	(#2)	(#3)			

SECTION B: RECOMMENDED IMMUNIZATIONS	The following immunizations are recommended for all students and may be required by certain colleges or departments (i.e., health sciences). Please consult with your college or department for specific requirements.					
Meningococcal vaccine:	No ()	Yes ()	Which Vaccine?	Meactra ()	Menomune ()	Date Given:
	MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR	
*Hepatitis B Series only					****anti-HBs Date & Result	
*Hepatitis A/B combination series						
*Varicella (Chicken Pox) series of two doses or immunity by positive blood titer				Disease Date	****Titer Date & Result	
*Tuberculin Skin Test (PPD) or TB blood test (within 12 months)	Date Read Report result in mm induration					
Chest X-Ray, if positive PPD	Date Results					
Treatment, if applicable	Date					

SECTION C: OPTIONAL IMMUNIZATIONS	MONTH/DAY/YEAR	MONTH/DAY/YEAR	MONTH/DAY/YEAR
*Haemophilus influenzae type b			
*Pneumococcal			
*Hepatitis A series only			
*HPV (Gardasil)			
*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 is acceptable, but must have signed statement from physician.
***Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.
****Lab report must be submitted.

MENINGOCOCCAL (MENINGITIS) DISEASE AND VACCINATION INFORMATION SHEET

Meningococcal Disease is a rare but potentially fatal bacterial infection caused most often by the bacterium *Neisseria meningitidis*. 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 indicate 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. 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 of 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 http://www.cdc.gov/ncidod/diseases/sub_meningitis.htm, consult your health care provider, or you may contact our Immunization Office by calling 336.334.4086.

STUDENT MEDICAL FORM

Please print in black ink. To be completed by student.

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	STUDENT ID#

Permanent Address _____	City _____	State _____	Zip Code _____	Phone Number _____
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> Other <input type="checkbox"/>		
Email Address _____				

Class you are entering (circle):	Previously Enrolled Here? (circle):	Semester Entering (circle):	Fall	Spring
Fr. So. Jr. Sr. Grad. Prof.	Yes No	Summer 1 Summer 2 Other		Year 20__

Name of Person to Contact in Case of Emergency _____	Relationship _____
Address _____	City _____ State _____ Zip 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 further 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			
Stroke				Diabetes				Type:			
Heart attack before age 55				Glaucoma				Psychiatric illness			
Blood or clotting disorder				Alcohol/Drug Problems				Suicide			

Have you ever had or have you now? (Please check the appropriate column to the right of each item and, if yes, indicate the 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 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				Irregular periods			
Pneumonia				Severe head injury				Eye trouble besides corrective lenses				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				Excessive worry or anxiety				Recurrent back pain				Drug use			
Specify:				Ulcer				Neck injury				Anorexia/bulimia			
Malaria				Specify: (duodenal or stomach)				Back injury				Smoke 1+ pack cigarette/week			
Thyroid trouble				Intestinal trouble				Broken bone				Regularly exercise			
Diabetes				Pilonidal cyst				Specify:				Wear seat belt			
Serious skin disease				Frequent vomiting				Kidney infection				Other (Specify):			
Mononucleosis				Gallbladder trouble or gallstones				Bladder infection				Other (Specify):			

Please list any drugs, medicines, birth control pills, vitamins and minerals (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 _____

STUDENT MEDICAL FORM

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 to the right, or on an attached sheet. Have you ever experienced any 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 checkup, have you seen a physician or healthcare 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 is 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 profession 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 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 is under age 18

Date