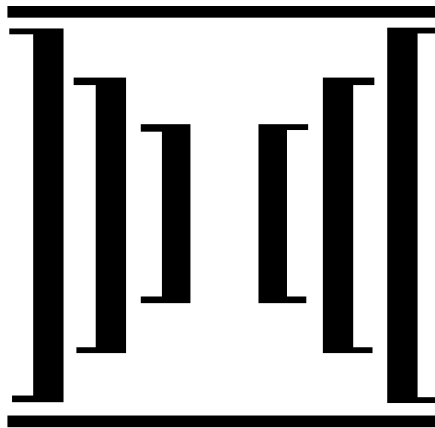


**Student Medical Form
for
North Carolina Community
College
System Institutions**



**Catawba Valley Community College
School of Health Services
Health Form Requirements**

When completing the Catawba Valley Community College (CVCC) Health Form, please note these additional instructions:

On Page 3:

Please use your CVCC college ID number in place of your social security number.

On Page 6:

Section A

- a. MMR and Varicella – there must be proof of two (2) doses **OR** a positive antibody titer.
- b. TDAP (Tetanus, Diphtheria and Pertussis) – Proof of immunization within the last ten (10) years.

Section B

- a. All of Section B is now required.
- b. Students must complete a 2 step PPD test within the last six (6) months.

Section C

Section C is strongly recommended.

On Page 7:

- a. Physical exam – all sections are required unless advised otherwise by the program director.
- b. Please note the box (only for students admitted to health services programs) **MUST** be completed. Noncompletion will result in returning the health form to the student to return to the healthcare provider for completion.

Have you had an adverse reaction to latex? If so, what was the reaction?

Student Signature

Date

REPORT OF MEDICAL HISTORY

(Please print in black ink)

To be completed by student

LAST NAME (print) _____ FIRST NAME _____ MIDDLE/MAIDEN NAME _____ PERSONAL ID#(PID) _____ *SOCIAL SECURITY NUMBER _____

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): FR. SO. JR. SR. GRAD. PROF.	PREVIOUSLY ENROLLED HERE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATES _____	SEMESTER ENTERING (circle): FALL SPRING SUMMER 1 SUMMER 2 OTHER YEAR 20____
	PREVIOUSLY A PATIENT HERE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATES _____	

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) _____		AREA CODE/TELEPHONE NUMBER _____
NAME OF POLICY HOLDER _____	*SOCIAL SECURITY NUMBER _____	EMPLOYER _____
POLICY OR CERTIFICATE NUMBER _____	GROUP NUMBER _____	IS THIS AN HMO/PPO/MANAGED CARE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO

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 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 need glasses				Sexually transmitted			
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, minerals, and any herbal/natural product (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 _____

* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

FAMILY & PERSONAL HEALTH HISTORY-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 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

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 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 physicians of the Student Health Service. **(Not applicable to community colleges.)**
- (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. **(Not applicable to community colleges.)**

Signature of Student

Date

Signature of Parent/Guardian, if student under age 18

Date

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 Services for help if needed. **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)
- 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 3	Polio 3	Measles ² 2	Mumps ⁴ 1	Rubella ⁴ 1
STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER				
DTP or Td ¹ 3	Polio 0	Measles ^{2,3} 2	Mumps ⁴ 1	Rubella ⁴ 1
STUDENTS BORN BEFORE 1957				
DTP or Td ¹ 3	Polio 0	Measles 0	Mumps 0	Rubella ⁴ 1
STUDENTS 50 YEARS OF AGE AND OLDER				
DTP or Td ¹ 3	Polio 0	Measles 0	Mumps 0	Rubella 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 even one day 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.
-------------------	--

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 page 6 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:	These vaccines are OPTIONAL .
-------------------	--------------------------------------

IMMUNIZATION RECORD		(Please print in black ink) To be completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.		
Last Name		First Name	Middle Name	Personal ID# (PID)
			Date of Birth (mo./day/year)	*Social Security #

SECTION A REQUIRED IMMUNIZATIONS				
	mo./day/year	mo./day/year	mo./day/year	mo./day/year
	(#1)	(#2)	(#3)	(#4)
• DTP or Td				
• Td booster				
• Polio				
• MMR (after first birthday)				
• MR (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

SECTION B RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

Meningococcal	Received the meningococcal vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/>
If Yes, please indicate date(s) vaccine was received (mo./day/year)	

	mo./day/year	mo./day/year	mo./day/year	
• Hepatitis B series only				****Titer Date & Result
OR				
• Hepatitis A/B combination series				
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
• Tuberculin (PPD) Test (within 12 months)	Date read			
	mm induration			
• Chest x-ray, if positive PPD	Date			
	Results			
• Treatment if applicable	Date			

SECTION C OPTIONAL IMMUNIZATIONS				
	mo./day/year	mo./day/year	mo./day/year	
• Haemophilus influenzae type b				
• Pneumococcal				
• Hepatitis A series only				
• Other				

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 City State Zip Code

- * Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.
- ** Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease 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.
- **** Attach Lab report

Do Not Write in This Space

CAL EXAMINATION*(Please print in black ink) To be completed and signed by physician*

A physical examination is required by **some schools and/or programs** (consult your college or department for specific requirements). **If required**, it must be completed in black ink and signed by a physician or 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 _____ / _____

IF REQUIRED: <u>Vision:</u> Corrected Right 20/ _____ Left 20/ _____ Uncorrected Right 20/ _____ Left 20/ _____ Color Vision _____ <u>Hearing:</u> (gross) Right _____ Left _____ 15 ft. Right _____ Left _____	IF REQUIRED: <u>Urinalysis:</u> Sugar: _____ Albumin _____ Micro _____ <u>Hgb or Hct</u> (if indicated) _____ <u>STS</u> (may be required by some departments) Date _____ Results _____ Recommendations _____
---	--

Are there abnormalities?	Normal	Abnormal	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. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
 Explain _____
- D. Is student physically and emotionally healthy? Yes _____ No _____
 Explain _____

• Only for Students Admitted to a **HEALTH SCIENCES PROGRAM** •

Based on my assessment of this student's physical and emotional health on _____, he/she appears able to participate in the activities of a health profession in a clinical setting. Yes _____ No _____ if no, please explain _____
 (Date)

Signature of Physician/Physician Assistant/Nurse Practitioner

Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Area Code/Phone Number

Office Address **City** **State** **Zip Code**

*Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.