



**Student Health Center Immunization Form
for**

Guilford College

5800 West Friendly Avenue
Greensboro, NC 27410

Phone 336-316-2194

FAX 336-316-2184

**A completed immunization record is required to be submitted to
Student Health prior to registration for courses.**

This form is due by May 31.

North Carolina Law G.S. 130A-155 requires persons attending college to present an immunization record. Required immunizations are listed in Section A. **Students not meeting these requirements must be immunized during the initial 30 days of the semester or be removed from college.** We request all students have current immunizations before coming to college.

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT

- **The Immunization Record form must be completed.**
- Records must be documented in black INK and all corrections must be signed.
- The records must list student's name, date of birth, sex, and address; 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.**
- Records must include a physician's signature, health department stamp or official high school record (with seal).
- **Please receive all immunizations before coming to campus.**

SECTION A Immunizations that are REQUIRED pursuant to NC state law and institutional policy.

Students 17 years of age or younger, REQUIRED:

- 4 DTP (Diphtheria, Tetanus, Pertussis) or (Tetanus, Diphtheria) doses; **one Td booster or Tdap must have been within the past 10 years.**
- 3 polio (oral) doses.
- 2 measles, mumps, rubella (**2 MMR doses meet this requirement**).
- Completed Consent To Treat Minor Form
- **International Students** - see notes below.

Students 18 years of age or older, REQUIRED:

- 4 DTP (Diphtheria, Tetanus, Pertussis) or (Tetanus, Diphtheria) doses; **one Td booster must have been within the past 10 years.**
- 2 measles, 2 mumps, 1 rubella (**2 MMR doses meet this requirement**).
- **International Students** - see notes below.

Notes:

- Blood titer tests are acceptable for Measles (Rubeola), Mumps, Rubella and Hepatitis B. Laboratory test results must be attached.

Transfer Students:

- **MUST** request immunization records separately from your transcripts.

International Students:

If you are an International Student (born outside the United States, currently live outside the United States, or have lived outside the United States for three months or more) - **you are required to have a TB test.** If the TB test is positive, you must have proof of a negative chest X-ray, treatment documentation (if required), no active symptoms and a note from your physician stating that you do not have active TB.

You must also have all your immunizations completed before arrival:

- 4 DTP (Diphtheria, Tetanus, Pertussis) or (Tetanus, Diphtheria) doses; **one Td booster or Tdap must have been within the past 10 years.**
- 3 polio (oral) doses.
- 2 measles, mumps, rubella (**2 MMR doses meet this requirement**) **or** blood titer test showing positive immunity to all three - signed by a physician.
- Tuberculin Skin Test (PPD) and result within the **twelve months preceding** the beginning of classes (chest x-ray report required if test is positive).

SECTION B These vaccines are **RECOMMENDED** by Guilford College, but are not required.

SECTION C These vaccines are **OPTIONAL** or for future use.

REQUIRED FOR INTERNATIONAL STUDENTS ONLY: PHYSICAL EXAMINATION

(Please print in black ink)

To be completed and **signed** by 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 _____ / _____

| | |
|---|---|
| <p>Vision Corrected Right 20/ _____ Left 20/ _____ Uncorrected Right 20/ _____ Left 20/ _____ Color Vision _____</p> <p>Hearing (gross) Right _____ Left _____ 15 ft. Right _____ Left _____</p> | <p>Urinalysis Sugar _____ Albumin _____ Micro _____</p> <p>Hgb or Hct (if indicated) _____</p> <p>TB Skin Test Results (mandatory) _____</p> |
|---|---|

| 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 _____

Signature of Physician/ Physician Assistant/Nurse Practitioner _____ Date _____

Signature of Physician/ Physician Assistant/Nurse Practitioner _____ Area Code/Phone Number _____

Office Address _____

**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.*

REQUIRED: Please send completed form by May 31 to: Student Health Center, Guilford College, 5800 W. Friendly Ave. Greensboro, NC 27410

IMMUNIZATION RECORD (Please print in black ink)

To be completed and **signed** by physician or clinic

Last Name First Name Middle Name Date of Birth (mo./day/year) * Social Security Number

SECTION A: REQUIRED IMMUNIZATIONS

| | mo./day/year | mo./day/year | mo./day/year | mo./day/year |
|---|----------------------------|--------------|---------------------------|------------------------|
| • DPT or Td (series of 4) | (#1) | (#2) | (#3) | (#4) |
| • Td or Tdap Booster (within last 10 years) | (#1) | | | |
| • Polio (series of 3) | (#1) | (#2) | (#3) | |
| • MMR (after first birthday - 2 doses) | (#1) | (#2) | | |
| • Measles (after first birthday) | | | Disease date | ** Titer date & Result |
| • Mumps (after first birthday) | | | Disease date NOT Accepted | ** Titer date & Result |
| • Rubella (after first birthday) | | | Disease date NOT Accepted | ** Titer date & Result |
| • Hepatitis B series (series of 3 required if born after 07-01-1994) | | | | ** Titer date & Result |
| • Tuberculin (PPD) Test (within 12 months) <u>(For international students only)</u> | Date read mm induration | | | |
| Chest x-ray, if positive PPD | Date read | | | |
| (ATTACH PHYSICIAN'S NOTE) | Results | | | |
| Treatment, if applicable | Date | | | ** attach lab report |

SECTION B: RECOMMENDED IMMUNIZATIONS - The following immunizations are recommended for all students, but are not required.

| | mo./day/year | mo./day/year | mo./day/year | |
|---|--------------|--------------|--------------|------------------------|
| • Varicella (chicken pox) series of two doses or immunity by positive blood titer | | Disease date | | ** Titer date & Result |
| • Meningococcal | | | | ** attach lab report |

SECTION C: OPTIONAL IMMUNIZATIONS

| | mo./day/year | mo./day/year | mo./day/year | |
|---------------------------------|--------------|--------------|--------------|--|
| • Haemophilus Influenzae type b | | | | |
| • Pneumococcal | | | | |
| • Hepatitis A Series | | | | |
| • Typhoid (specify type) | | | | |
| • Gardasil | | | | |
| • 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

REQUIRED FOR ALL STUDENTS

**Please send completed form by May 31 to: Student Health Center, Guilford College,
5800 W. Friendly Ave. Greensboro, NC 27410**

| | |
|--|--|
| REPORT OF MEDICAL HISTORY (Please print in black ink) | <i>To be completed and signed by student</i> |
|--|--|

LAST NAME (print) FIRST NAME MIDDLE NAME *SOCIAL SECURITY NUMBER _____

PERMANENT ADDRESS CITY STATE ZIP AREA CODE / PHONE _____

E-MAIL ADDRESS _____ CELL PHONE # _____

DATE OF BIRTH (mo/day/yr) _____ GENDER M F MARITAL STATUS M S OTHER

| | | |
|---|---|--|
| CLASS YOU ARE ENTERING (circle): FR. SO. JR. SR. GRAD. PROF. | PREVIOUSLY ENROLLED HERE <input type="checkbox"/> YES <input type="checkbox"/> NO PREVIOUSLY A PATIENT HERE <input type="checkbox"/> YES <input type="checkbox"/> NO | SEMESTER ENROLLING (circle): FALL SPRING SUMMER1 SUMMER2 OTHER YEAR _____ |
|---|---|--|

HOSPITAL / HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) _____ AREA CODE / PHONE _____

NAME OF POLICY HOLDER _____ * SOCIAL SECURITY NUMBER EMPLOYER _____

POLICY OR CERTIFICATE NUMBER GROUP NUMBER _____ IS THIS AN HMO/MANAGED CARE PLAN? YES NO

NAME OF PERSON AND TELEPHONE TO CONTACT IN CASE OF AN EMERGENCY _____ RELATIONSHIP _____

PARENT WORK NUMBER _____ ARE YOU COVERED IN NC TO SEE A DOCTOR OR URGENT CARE FOR OTHER THAN EMERGENCY? YES NO

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) | <i>To be completed by student</i> |
|---|-----------------------------------|

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 disorders | | | | Cancer (type) | | | |
| Stroke | | | | Diabetes | | | | Alcohol / drug problems | | | |
| Heart attack before age 55 | | | | Glaucoma | | | | Psychiatric illness | | | |
| Blood or clotting disorders | | | | | | | | Suicide | | | |

Height _____ Weight _____

Have you had or have you now: (please check at right of each item)

| | Yes | No |
|------------------------------|-----|----|
| ADD / ADHD | | |
| Alcohol use | | |
| Allergy injection therapy | | |
| Anemia or Sickle Cell Anemia | | |
| Anorexia / Bulimia | | |
| Anxiety | | |
| Aspergers | | |
| Asthma | | |
| Bipolar Illness | | |
| Blood transfusion | | |

| | Yes | No |
|-----------------------------|-----|----|
| Concussion | | |
| Depression | | |
| Diabetes | | |
| Drug use | | |
| Epilepsy / Seizures | | |
| Frequent/Migraine headaches | | |
| Hay fever / Allergies | | |
| Heart trouble | | |
| High blood pressure | | |
| Intestinal trouble | | |
| Mononucleosis | | |

| | Yes | No |
|------------------------------|-----|----|
| Other learning disability | | |
| Pilonidal cyst | | |
| Sexually transmitted disease | | |
| Smoke 1+ pack cigarettes/wk | | |
| Tuberculosis | | |
| Tumor or cancer (specify) | | |
| Thyroid trouble | | |
| Ulcer (duodenal or stomach) | | |
| Other (specify) | | |
| | | |

Do you use an epi-pen? Yes No

Do you exercise three or more times per week? Yes No

Do you use a seat belt on a regular basis? Yes No

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

1 _____ 3 _____

2 _____ 4 _____

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FAMILY AND 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.

| | Yes | No | Explanation |
|---|-----|----|-------------|
| Penicillin | | | |
| Sulfa | | | |
| Other antibiotics (name) | | | |
| Aspirin | | | |
| Codeine or other pain relievers | | | |
| Other drugs, medicines, chemicals (specify) | | | |
| Insect bites | | | |
| Food allergies (specify) | | | |
| Require an epi-pen | | | |
| | Yes | No | Explanation |
| 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

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 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. I accept personal responsibility for settling the account with the Business Office for incurred charges. I am responsible for filling out patient charges with insurance and acknowledge that my responsibility to Guilford College is unaffected by the existence of insurance coverage.

Signature of Student

Date

Signature of Parent/Guardian, if student is under age 18

Date