CONTINUING EDUCATION & GRADUATE STUDENTS IMPORTANT INFORMATION

Any CE (adult) student taking 2 or more daytime (before 5:00 pm) classes is **REQUIRED to meet the following NC state law immunization requirements:**

▪ **At least 3 DTP (Diphtheria, Tetanus, Pertussis) or 3 (Tetanus, Diphtheria) doses. One Tetanus Booster or Tdap must have been within the last 10 years**. NOTE: If it has been more than 10 years since your last Tetanus shot, you must get the Tetanus shot that has Pertussis in it, called a (Tdap).

▪ **2 MMR (measles, mumps, rubella) shots.**
Blood titer tests are acceptable for Measles (Rubeola), Mumps, Rubella. **Laboratory test results must be attached and show positive immunity to all three diseases.** Keep in mind that most insurances do not pay for the titer.

▪ **3 Hepatitis B shots.**
Required only if you were born after July 1, 1994. Hepatitis blood titer is NOT acceptable.

In addition to these requirements, you must have a **Tuberculin (PPD) skin test** if you are an international student. If the TB skin 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.

GUIDELINES FOR COMPLETING CE (ADULT STUDENT) IMMUNIZATION FORM

IMPORTANT: Please read BEFORE having form completed:
If you are a graduate student living on campus OR Taking 4 or more credits before 5pm Monday-Friday you must submit your immunization records and report of medical history. If you are a graduate student living off campus AND taking fewer than 4 credits before 5pm Monday-Friday you do not have to turn in your records.

▪ Records must be signed and dated by a physician, nurse practitioner, or physician assistant. The medical provider's address must also be on the form. The record 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 physician, health department, military, or previously attended college. The Permanent Health Record, which may be part of your public school record, is acceptable; High school transcripts themselves are not acceptable, but the information on them is helpful. Keep in mind that these records may not fulfill all requirements, so you must follow up with our office to determine your immunization status.

It is your responsibility to assure compliance with required immunizations.

▪ If you are from North Carolina, or lived here during your childhood, you may have records that can be accessed through the North Carolina Immunization Registry (NCIR) data base. In addition, if you have received immunizations at a local Health Department, the shots should be available on the NCIR. This is an excellent resource and immunization records printed from the NCIR are acceptable. If you think you may have records in the NCIR, contact Susan Smith at ssmith@guilford.edu. The Student Health Center is closed each June and July, but we check our email periodically. We return to our office on August 1st, and may be reached then by phone: 336-316-2194.

If you are unable to locate any of your immunization records, you will need to be re-immunized in accordance with the Centers for Disease Control (CDC) vaccination schedule.

GUILFORD
COLLEGE

CE IMMUNIZATION FORM

Please read and follow the instructions on The Guidelines For CE Student Immunization Form.
Remember:

- Please keep a copy for your records
- Remember that All dates must have the month/day/year
- The form must be completed and signed by physician, PA, or NP; Signature, address and phone section must be completed

Return to: Guilford College Student Health Center, 5800 W. Friendly Avenue, Greensboro, NC 27410

Last Name First Name Middle Date of Birth *(month/day/year)*

Address Sex

G # _____ Phone # _____

DTP or Td (series of 3/4)	#1	#2	#3
Td or Tdap Booster in the last 10 years *(Circle one)*	#1		
MMR (Measles, Mumps, Rubella)	#1	#2	
If submitting MMR titer results, must submit laboratory test results that show positive immunity to all three diseases.			
Hepatitis B Series (series of 3 doses)*	#1	#2	#3
*Hepatitis B is not required if you were born before July 1, 1994.			

In addition to these requirements, you must have a TB skin test if you are an international student.

If the TB skin test is positive, you must have proof of a negative chest x-ray, treatment documentation (if required), no active symptoms, and a note from a physician stating you do not have active TB.

Tuberculin (PPD) Test (within 12 months)	Date read	
Chest x-ray – if positive PPD	Date read	mm induration:
(Attach physicians note) Treatment, if applicable	Results Date	

Signature of Physician/Nurse Practitioner/Physician Assistant Date

Print Name of Physician/PA/NP Area Code/Phone Number

Office Address

REQUIRED FOR ALL STUDENTS
REPORT OF MEDICAL HISTORY

(Please print in black ink) ***To be completed and signed by student***

LAST NAME (print) FIRST NAME MIDDLE NAME

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 ❑ YES ❑ NO

SEMESTER ENROLLING (circle): FALL SPRING

Guilford College requires that all students are covered by a medical insurance plan. Please complete this information and/or attach a (front and back side) copy of your current medical health insurance card(s).
For more information, go to www.guilford.edu/StudentHealth.

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

NAME OF POLICY HOLDER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

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.

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		
Autism Spectrum Disorder		
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)		

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_____

PERSONAL HEALTH HISTORY, CONTINUED (Please print in black ink) *To be completed by student*.

Check each item "Yes" or "No." Every item checked "Yes" explain in the space on the right.

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain.

	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 Services 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.

Signature of Student Date

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