A completed immunization record is required to be submitted to Student Health prior to registration for courses. This form is due by June 30.

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 the College.

We request all students have current immunizations before coming to the College.
GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT
• Our form (page 4 of this document) must be used to complete the immunization record.
• Records must be documented in black INK and signed by a physician.
• 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 physician, health department 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 and address.
• Please receive all immunizations before coming to campus.
• Keep a copy of your Immunization Record and this document for your records.

SECTION A IMMUNIZATIONS THAT ARE REQUIRED PURSUANT TO NC STATE LAW AND INSTITUTIONAL POLICY FOR TRADITIONAL STUDENTS:
• 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).
• Hepatitis B series (3 doses required)

Notes:
• Blood titer tests are acceptable for Measles (Rubeola), Mumps, Rubella and Laboratory test results must be attached.

International Students:
You are considered an international student if you were born outside the United States, currently live outside of the US, or have lived outside the United States for three months or more. If any of these situations apply, 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).
• Hepatitis B series (3 doses required)
• A Physical Examination is also required. Please use our form.
• Records must be complete in English.
• Keep a copy for your records.

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 AND TB SKIN TEST**

(Please print in black ink)  
To be completed and signed by physician or clinic

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth (mo./day/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Area Code/Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>TPR</th>
<th>/</th>
<th>/</th>
<th>BP</th>
<th>/</th>
<th></th>
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<tbody>
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</tbody>
</table>

**Vision**  
Corrected  
Right 20/_______  Left 20/_______

Uncorrected  
Right 20/_______  Left 20/_______

Color Vision  

**Hearing**  
(gross) Right_______ Left_______

15 ft.  
Right_______ Left_______

**Urinalysis**  
Sugar _________ Albumin_______

Micro_______

Hgb or Hct (if indicated)_______

**TB Skin Test Results (mandatory)**

Are there abnormalities?  
1. Head, Ears, Nose, Throat
   - Normal
   - Abnormal
   - DESCRIPTION (attach additional sheets if necessary)

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
REQUIRED FOR ALL STUDENTS: PLEASE SEND COMPLETED FORM TO: STUDENT HEALTH SERVICES, 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

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth (mo./day/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Address</th>
<th>Parent’s Name (if under 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION A: REQUIRED IMMUNIZATIONS

All dates must have month/day/year

<table>
<thead>
<tr>
<th>Immunization</th>
<th>First Date (mo./day/year)</th>
<th>Second Date (mo./day/year)</th>
<th>Third Date (mo./day/year)</th>
<th>Fourth Date (mo./day/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT or Td</td>
<td>(#1)</td>
<td>(#2)</td>
<td>(#3)</td>
<td>(#4)</td>
</tr>
<tr>
<td>Td or Tdap Booster within the last 10 years</td>
<td>(#1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>(#1)</td>
<td>(#2)</td>
<td>(#3)</td>
<td></td>
</tr>
<tr>
<td>MMR (2 doses)</td>
<td>(#1)</td>
<td>(#2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B series (series of 3)</td>
<td>(#1)</td>
<td>(#2)</td>
<td>(#3)</td>
<td>* Titer not accepted</td>
</tr>
<tr>
<td>Tuberculin (PPD) Test (within 12 months)</td>
<td>Date read</td>
<td>mm induration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(For international students only)

Chest x-ray, if positive PPD

(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.

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date (mo./day/year)</th>
<th>Disease date</th>
<th>** Titer date &amp; Result</th>
<th>** attach lab report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella (chicken pox) series of two doses or immunity by positive blood titer</td>
<td>Date</td>
<td>Disease date</td>
<td>** Titer date &amp; Result</td>
<td>** attach lab report</td>
</tr>
<tr>
<td>Meningococcal and Booster</td>
<td>Date</td>
<td></td>
<td>** attach lab report</td>
<td></td>
</tr>
</tbody>
</table>

SECTION C: OPTIONAL IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date (mo./day/year)</th>
<th>Date (mo./day/year)</th>
<th>Date (mo./day/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemophilus Influenzae type b</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A Series</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid (specify type)</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gardasil</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature or Clinic Stamp REQUIRED:

Signature of Physician / Date

Print Name of Physician / Area Code / Phone Number

Office Address
REQUIRED FOR ALL STUDENTS
Please send completed form by June 30 to:
Student Health Services, Guilford College, 5800 W. Friendly Ave. Greensboro, NC 27410

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): PREVIOUSLY ENROLLED HERE □ YES □ NO SEMESTER ENROLLING (circle): FALL SPRING
FR. SO. JR. SR. GRAD. PROF. PREVIOUSLY A PATIENT HERE □ YES □ NO SUMMER1 SUMMER2 OTHER YEAR

HOSPITAL / 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

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) To be completed by student

Has any person, related by blood, had any of the following:

High blood pressure Yes □ No □ Relationship: Yes □ No □
Cholesterol or blood fat disorders
Stroke Yes □ No □ Relationship: Yes □ No □
Diabetes
Heart attack before age 55 Yes □ No □ Relationship: Yes □ No □
Glaucoma
Blood or clotting disorders Yes □ No □ Relationship: Yes □ No □
Suicide

Height: ____________ Weight: ____________

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

ADD / ADHD Yes □ No □
Alcohol use Yes □ No □
Allergy injection therapy Yes □ No □
Anemia or Sickle Cell Anemia Yes □ No □
Anorexia / Bulimia Yes □ No □
Anxiety Yes □ No □
Aspergers Yes □ No □
Asthma Yes □ No □
Bipolar illness Yes □ No □
Blood transfusion Yes □ No □
Concussion Yes □ No □
Depression Yes □ No □
Diabetes Yes □ No □
Drug use Yes □ No □
Epilepsy / Seizures Yes □ No □
Frequent / Migraine headaches Yes □ No □
Hay fever / Allergies Yes □ No □
Heart trouble Yes □ No □
High blood pressure Yes □ No □
Intestinal trouble Yes □ No □
Mononucleosis Yes □ No □

Other learning disability Yes □ No □
Pelvis cyst Yes □ No □
Sexually transmitted disease Yes □ No □
Smoke 1+ pack cigarettes/wk Yes □ No □
Tuberculosis Yes □ No □
Tumor or cancer (specify) Yes □ No □
Thyroid trouble Yes □ No □
Ucer (duodenal or stomach) Yes □ No □
Other (specify) Yes □ No □

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 ___________________________
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.

<table>
<thead>
<tr>
<th>Drug/Condition</th>
<th>Yes</th>
<th>No</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penicillin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sulfa</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other antibiotics (name)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Aspirin</td>
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<tr>
<td>Codeine or other pain relievers</td>
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<td></td>
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<tr>
<td>Other drugs, medicines, chemicals</td>
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<td></td>
<td></td>
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<tr>
<td>Insect bites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food allergies (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Require an epi-pen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been a patient in any type of hospital? (Specify when, where, and why?)</td>
<td>Yes</td>
<td>No</td>
<td>Explanation</td>
</tr>
<tr>
<td>Has your academic career been interrupted due to physical or emotional problems? (Please explain.)</td>
<td>Yes</td>
<td>No</td>
<td>Explanation</td>
</tr>
<tr>
<td>Is there loss or seriously impaired function of any paired organs? (Please describe.)</td>
<td>Yes</td>
<td>No</td>
<td>Explanation</td>
</tr>
<tr>
<td>Other than for a routine check-up, have you seen a physician or health care professional in the past six months? (Please describe.)</td>
<td>Yes</td>
<td>No</td>
<td>Explanation</td>
</tr>
<tr>
<td>Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details.)</td>
<td>Yes</td>
<td>No</td>
<td>Explanation</td>
</tr>
</tbody>
</table>

**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
Meningococcal Disease is caused by bacteria called Neisseria meningitides and is spread from person to person through respiratory secretions. Some individuals can be infected with the bacteria and yet not exhibit any symptoms. They are unaware of the infection, yet can spread it to others. Others who are exposed to these bacteria will get significant infection, sometimes resulting in death. If the bacteria invade the bloodstream or other body tissues it can cause meningitis (inflammation of the membranes surrounding the brain and spinal cord), sepsis (infection of the blood stream), pneumonia, or pharyngitis (sore throat).

Studies show that freshmen entering college and residing in residential halls are at an increased risk of this disease, relative to other persons of similar age. Due to this, it is recommended by the Center of Disease Control (CD) that this vaccine is offered for other college students wanting to reduce their risk of this disease.

The vaccinations available that prevent Meningitis do not contain live bacteria. They are 85-90% effective in preventing disease from serotypes A, C, and Y and W-35, but they do not protect against the serotype B. There is now a specific vaccine that does provide protection against serotype B. Ask your health care provider to health department about this additional Meningitis vaccine.

Guilford College recommends that students discuss the Meningitis vaccines with their primary care provider or local health department prior to coming to college. The vaccinations are also available from Greensboro area medical providers and the Guilford County Health Department.

For more information about this disease and the vaccines contact:

- http://www.immunize.nc.gov/family/vaccines/meningococcal.htm
- The Center for Disease Control: http://www.cdc.gov/meningitis/index.htm
- American College Health Association: www.acha.org