



Health & Counseling Center
100 Campus Drive
2040 Campus Box
Elon, NC 27244
336-278-7230 (phone)
336-538-6506 (fax)

THE R.N. ELLINGTON HEALTH & COUNSELING CENTER

Dear Student:

The staff at the R.N. Ellington Health & Counseling Center welcomes you to Elon University. We hope your experiences will be rewarding, enjoyable and healthy.

North Carolina Public Health law requires proof of immunization to protect you and others while you are at Elon University. You should review the following regulations and recommendations as they apply to you. **Please note that North Carolina state law requires that immunizations be completed thirty days following matriculation. After the thirty days disenrollment procedures will begin for students that are not in compliance until required immunizations are documented.**

Please complete the attached form accurately with **completed dates** and types of vaccines. This information can be obtained from your physician, health department, and military record or previously attended college. We strongly suggest the use of our Immunization Record form for obtaining the most accurate information. However you may attach copies that have your doctor's signature, address, your name, your address, date of birth, and sex. All required forms are to be signed and dated with all other required information by your medical provider. Attachments that do not have the required information will not be accepted.

Please keep a copy of the form for your records for clinical purposes.

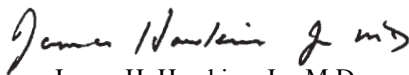
Please review the immunization requirements thoroughly. Give special attention to having a tuberculin skin test and the results. Tuberculin skin test are good for 1 year. Expired test, screenings, and Tine test will not be accepted.

COMPLETED HEALTH FORMS ARE DUE NOVEMBER 1ST.

All Elon University students are required to maintain health insurance either via an employment, parent, or spouse policy or through participation in the student health insurance policy marketed by Collegiate Risk Management. Information may be obtained by calling 1-800-222-5780 or visit their website at www.collegiaterisk.com

Please note that student health records are confidential and can only be released with the signed permission of the student. You can reach Health Services at (336) 278-7230. Student Health Services provides a variety of medical and other health services information that can be viewed on our web site at http://www.elon.edu/e-web/students/health_services/.

Leigh-Anne Royster
Director of Student Development


James H. Hawkins, Jr., M.D.
Medical Director



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Please complete the forms accurately with **completed dates** including month, day, and year, along with the types of vaccines. We strongly suggest the use of our Immunization Record for obtaining the most accurate information. This information can be obtained from your physician, health department, and military record or previously attended college. All attachments must have your doctor's signature, address, your name, your address, date of birth and sex. All required forms are to be signed and dated with all other required information by your medical provider. Please note that attachments that do not have the required information will not be acceptable. **Please keep a copy of the form for your records.**


COMPLETED HEALTH FORM DUE NOVEMBER 1ST

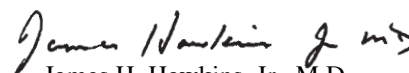
Please review the immunization requirements thoroughly. The DPT program has additional requirements. Please give special attention to the Varivax series (2 doses) or lab report showing immunity to chicken pox (Varicella titer).

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Students with specific medical problems are encouraged to see a provider soon after arriving on campus. These students should also bring with them copies of their medical records.

Please note that student health records are confidential and can only be released with the signed permission of the student. You can reach Health Services at (336) 278-7230. Student Health Services provides a variety of medical and other health services information that can be viewed on our web site at and in our brochure.


Katherine E. Parrish, F.N.P.
Director of Health Services


James H. Hawkins, Jr., M.D.
Medical Director

Comp.
Inits.

R. N. Ellington Health Center
Elon University, CB 2040
Elon, NC 27244
Phone: 336-278-7230 Fax: 336-538-6506

DPT

REPORT OF MEDICAL HISTORY (please print in black ink) To be completed by student

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

PERMANENT ADDRESS CITY STATE ZIP AREA CODE/PHONE

DATE OF BIRTH (mo./day/year) GENDER M F MARITAL STATUS S M

PREVIOUSLY ENROLLED HERE YES NO If yes, what year

PREVIOUSLY A PATIENT HERE YES NO If yes, what year

YEAR ENTERING: 20 ____

HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) TELEPHONE

NAME OF POLICY HOLDER SOCIAL SECURITY NUMBER EMPLOYER

IS THIS AN HMO/PPO/MANAGED CARE PLAN? YES NO

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY RELATIONSHIP

ADDRESS AREA CODE/PHONE

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 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			

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				
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 needing glasses				Sexually transmitted disease			
Chronic cough				Paralysis				Bone, Joint or other deformity				Blood transfusion			
Tuberculosis				Epilepsy/Seizures				Shoulder dislocations				Smoke (#Cigarettes a day) ____			
Head or neck radiation				Disabling depression				Knee problems				Alcohol use/Drug use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				ADHD/ADD			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Personal Trauma			
Diabetes				Pilonidal cyst				Broken bone (specify)				Serious skin disease			
Frequent vomiting				Kidney infection				Mononucleosis				Gall bladder trouble or gallstones			
Bladder infection				Chicken Pox								Other (specify)			

PERSONAL HISTORY-CONTINUED (please print in black ink) To be completed by student

Please list any known drug allergies and reactions: _____

Please list any food allergies and reactions: _____

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

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
 Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
 Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

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).

	Yes	No	Explanation
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Is there loss or seriously impaired function of any paired organ? (please describe)			
Other than for a routine checkup, have you seen a physician or health-care professional in the past 6 months? (please describe)			
Have you ever had a serious illness or injuries other than those already noted? (specify when and where and give details)			
Have you ever been treated? yes <input type="checkbox"/> no <input type="checkbox"/> ; hospitalized? yes <input type="checkbox"/> no <input type="checkbox"/> ; or presently on medication for emotional/psychological concerns? yes <input type="checkbox"/> no <input type="checkbox"/> ; (please describe)			

IMPORTANT INFORMATION...PLEASE READ AND COMPLETE

STATEMENT BY STUDENT OR PARENT/GUARDIAN, IF STUDENT UNDER AGE OF 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 a 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 providers of the Student Health Services.
- (C) **I am aware that the Student Health Services charges for some services and I may be billed through the University Bursar if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Bursar and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge my responsibility to the University by the existence of insurance coverage.**

Signature of Student _____ Date _____

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

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

DPT STUDENTS

- ❑ The Immunization Record form must be completed. All dates must include **month, day** and **year** of administration.
- ❑ Records must include a clinician's signature, health department stamp.

IMMUNIZATION REQUIREMENTS PURSUANT TO NC STATE LAW

College/University Vaccine Requirements and Number of Doses

Diphtheria Tetanus and/or Pertussis	Measles	Mumps	Rubella
3 ₁	2 ₂	2 ₃	1 ₄

Footnote 1: 3 doses of tetanus/diphtheria toxoid of which one must have been within the past 10 years. ONE OF THOSE DOSES MUST HAVE BEEN Tdap UNLESS ANY OF THE FOLLOWING OCCUR; ENTERED COLLEGE OR UNIVERSITY PRIOR TO JULY 1, 2008; A BOOSTER DOSE OF Td WAS GIVEN WITHIN THE LAST 10 YEARS.

Footnote 2: Measles vaccines are not required if any of the following occur; Diagnosis of disease prior to January 1, 1994; Born prior to 1957; Enrolled in college or university for the first time before July 1, 1994; An individual who has been documented by serological testing to have a protective antibody titer against measles.

Footnote 3: Mumps vaccines are not required if any of the following occur; Born prior to 1957; Enrolled in college or university before July 1, 1994; An individual who has been documented by serological testing to have a protective antibody titer against mumps.

Footnote 4: 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

INSTITUTIONAL IMMUNIZATION REQUIREMENTS

- ❑ Tuberculin Skin Test (PPD) and result in millimeters within one year of beginning classes. (a chest x-ray report is required if test is positive) Tine test and screenings are not accepted.

NOTE. . . .

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

COMPLETED HEALTH FORM DUE DECEMBER 1ST

IMMUNIZATION RECORD

Part I

Name _____
(Last) (First) (Middle)

Date of Birth ____/____/____ Social Security # ____-____-____

Part II--TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

REQUIRED IMMUNIZATIONS

Diphtheria/Pertussis/Tetanus: Completed primary series with DTaP or DTP and booster with Td in the last ten years.

#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____ #5 ____/____/____

Tetanus-Diphtheria (Td) booster within the last ten years ____/____/____

M.M.R. (Measles, Mumps, Rubella) (Two doses required.) 1st dose must be on or after 1st birthday.

Dose 1 given at age 12-15 months or later ____/____/____

Dose 2 given at age 4-6 years or later, and at least one month after first dose. ____/____/____

(A positive Measles, Mumps, Rubella antibody titer meets the requirement. Lab report must be attached.)

Varicella Series of two doses or titer required. History of disease not acceptable.

#1 ____/____/____ #2 ____/____/____ Titer drawn: ____/____/____ (attach Lab report)

TUBERCULIN TEST (PPD) Must be within one year prior to matriculation. Each test are only good for 1 year

Date Given ____/____/____ Date Read ____/____/____ Result: _____ mm in duration

If positive skin test (over 10mm in duration): Date of chest x-ray ____/____/____

*If BCG was given over 2 years ago, tuberculin skin test needs to be given.

Hepatitis B Series must be started before attending Elon and completed as soon as possible.

#1 ____/____/____ #2 ____/____/____ #3 ____/____/____

(*Series must be complete before starting clinicals)

PLEASE KEEP A COPY OF THIS FOR YOUR RECORDS. YOU WILL NEED THEM WHEN YOU GO ON YOUR CLINICALS.

HEALTH CARE PROVIDER

Name _____ Address _____

Signature _____ Phone (____) _____ Fax (____) _____

Please forward to: Elon University
Health & Counseling Center
100 Campus Drive
2040 Campus Box
Elon, NC 27244

PHYSICAL EXAMINATION(please print in black ink) To be completed and **signed** by physician or clinic

Must be completed by a licensed physician, physician's assistant or nurse practitioner.

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

HEIGHT _____ WEIGHT _____ TPR _____ / _____ / _____ BP _____ / _____

Vision: Corrected	Right 20/_____	Left 20/_____	Urinalysis: (if indicated) Sugar _____ Albumin _____ Micro _____
Uncorrected	Right 20/_____	Left 20/_____	
Hearing: (gross)	Right _____	Left _____	Hgb or Hct (if indicated) _____

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 _____

Based on my assessment of this student's physical and emotional health on _____, he/she appears able to participate in all activities. Yes _____ No _____ If no, please explain _____

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

Print Name of Physician/Physician Assistant/Nurse Practitioner _____ Date _____ Fax # _____