

ELON UNIVERSITY

REQUIRED GRADUATE IMMUNIZATION AND MEDICAL HISTORY FORM

THIS IS REQUIRED INFORMATION

Complete this form and return **by July 1st** to:

STUDENT HEALTH SERVICES
2040 Campus Box
Elon, NC 27244
Phone: (336) 278-7230
Fax: (336) 538-6506
healthservices@elon.edu

North Carolina law requires a documentation of immunizations to be on file with Student Health Services prior to the first day of class. Failure to comply will result in **ADMINISTRATIVE WITHDRAWAL** from the university.

- University policy and state regulations require that prior to the start of classes all new students submit a medical history form and documentation of all required immunizations. No physical exam is required.
- Any attachments must include student name, address, date of birth, sex and medical provider's signature.
- Please keep a copy of the form for your records.
- All students are required to provide proof of insurance and maintain current insurance information on file.
- **You will not be able to move into your residence hall until all requirements are complete.**
- This form is for **GRADUATE (iMedia and School of Law)** students

Complete
Initials

Elon University Student Health Services
 2040 Campus Box
 Elon, NC 27244
 Phone: 336-278-7230 Fax: 336-538-6506

GRADUATE

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

Last Name First Name Middle Name (Preferred Name) Date of birth (MM/DD/YY) Student ID number

Permanent Address City State Zip Student Contact Number

Sex assigned at birth: M F Gender identity (choose all that apply): Man Woman Trans or transgender Other _____

CLASS YOU ARE ENTERING (circle) FR. SO. JR. SR.	Previously enrolled here? <input type="checkbox"/> YES <input type="checkbox"/> NO _____ YR.	SEMESTER ENTERING (circle): fall winter spring sumr1 sumr2 year 20_____
	Previously a patient here? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Health Insurance (Name and address of company) Telephone

Name of Policyholder 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 emergency Relationship

Address Area Code/ Phone number

Please attach a copy of the front and back of your health insurance card. If your insurance policy or provider changes you will need to provide a copy of the new card.

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

Please list allergies and reactions below (food, medication, other):

Please list any operations/surgeries and dates below:

Please list name and dose of all prescription medications taken below:

Name _____ Dose _____	Name _____ Dose _____
Name _____ Dose _____	Name _____ Dose _____
Name _____ Dose _____	Name _____ Dose _____
Name _____ Dose _____	Name _____ Dose _____

Please list any non-prescription medication/supplements/vitamins/herbs/natural remedies that you take:

Please list all current physical or emotional conditions for which you take medication or see a physician or therapist. Place a check mark beside any conditions you wish providers at Elon University Student Health Services (in partnership with Cone Health/Alamance Regional) to assist in managing or referring to a local specialist.

<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____

If you have checked any of the above items, please email this document to healthservices@elon.edu so we can coordinate resources prior to your arrival on Campus.

Information received by Elon University Student Health Services is protected by law and is not released to any other University offices or administrators without express written authorization of the patient or in the event of an emergency.

If you wish to disclose any conditions to any other Elon University offices or administrators, please complete and submit the disclosure form located on Student Health Services website.

For academic accommodations please contact Academic Support and Disability Services at 336-278-6500.

IMPORTANT INFORMATION...PLEASE READ AND COMPLETE

STATEMENTS MUST BE INITIALED AND SIGNED BY STUDENT (AND PARENT/ GUARDIAN, IF STUDENT IS UNDER THE AGE OF 18):

____ I have personally supplied and/or 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 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 or medical care.

____ I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by providers of the Student Health Services.

____ I am aware that Student Health Services does not file claims with health insurance companies. I understand there are charges for some services and I may be billed through my University student account if charges are not paid at the time of visit. Receipts that can be used by the patient to submit insurance reimbursement claims are provided upon request. I accept personal responsibility for settling the account with the Bursar's Office and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge my responsibility to the university by existence of insurance coverage.

____ I understand that Elon University Student Health Services requires that patients sign an intake form for each date of service that includes the option to release information to others for that date of service only. This does not mean information is automatically shared. Student Health does not accept "blanket" releases of medical information for future visits.

Signature of Student (required even if student is under the age of 18) Date

Signature of Parent/ Guardian (if student is under the age of 18) Date

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

UNDERGRADUATE STUDENTS

- The Immunization Record form must be completed and include patient first and last name, date of birth, and student ID number. All dates must include **month, day and year** of administration. Records must include a clinician's signature or health department stamp.
- TB Screening Questionnaire (and TB Risk Assessment if applicable) must be submitted even if all answers are "no".

INSTITUTIONAL IMMUNIZATION REQUIREMENTS

IMMUNIZATION REQUIREMENTS PURSUANT TO NC STATE LAW

College/University Vaccine Requirements and Number of Doses					
Diphtheria Tetanus and/or Pertussis	Polio	Measles	Mumps	Rubella	Hepatitis B
3 ₁	3 ₂	2 ₃	2 ₄	1 ₅	3
<p>Footnote¹ - DTP (Diphtheria, Tetanus, Pertussis), DTaP (Diphtheria, Tetanus, acellular Pertussis), Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, Pertussis): 3 doses of tetanus/diphtheria toxoid one of which must have been within the past 10 years.</p> <p>Those individuals enrolling in college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid and a booster dose of tetanus/diphtheria/pertussis vaccine if a tetanus/diphtheria toxoid or tetanus/diphtheria/pertussis vaccine has not been administered within the past 10 years.</p> <p>Footnote² - An individual attending school who has reached his or her 18th birthday is not required to receive polio vaccine.</p> <p>Footnote³ - Measles vaccines are not required if any of the following occur: Diagnoses of disease prior to January 1, 1994; an individual who has been documented by serological testing to have a protective antibody titer against measles; or an individual born prior to 1957. An individual who enrolled in college or university for the first time before July 1, 1994 is not required to have a second dose of measles vaccine.</p> <p>Footnote⁴ - Mumps vaccine is not required if any of the following occur: an individual who has been documented by serological testing to have a protective antibody titer against mumps; an individual born prior to 1957; or enrolled in college or university for the first time before July 1, 1994. An individual entering college or university prior to July 1, 2008 is not required to receive a second dose of mumps vaccine.</p> <p>Footnote⁵ - 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.</p>					

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 will be accepted		
Last Name	First Name	Middle Name	Date of birth (MM/DD/YY)	Student ID number

SECTION A: REQUIRED IMMUNIZATIONS	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)
DTP or Td				
Tdap (adult dose)				
Polio				
MMR (after first birthday)				***Tiiter date & result (not required)
MR (after first birthday)				***Tiiter date & result (not required)
Measles (after first birthday)			*Disease Date	***Tiiter date & result (not required)
Mumps			**Disease date NOT accepted)	***Tiiter date & result (not required)
Rubella			**Disease date NOT accepted)	***Tiiter date & result (not required)
Hepatitis B series				***Tiiter date & result (not required)

SECTION B: RECOMMENDED and OPTIONAL IMMUNIZATIONS	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)	(MM/DD/YY)
Meningococcal				
Varicella				
Hepatitis A				
HPV				
Seasonal Flu				
Haemophilus influenza type b				
Pneumococcal				
Other				

SECTION C: TB Test (if required; see attachment) administration date	Date read and result (in millimeters)	Chest x-ray results (if skin test positive) Must attach management plan

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

*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 vaccine is not taken. History of rubella or mumps disease, even from physician, is not acceptable.

***MUST ATTACH LAB REPORT

Tuberculosis (TB) Screening Questionnaire
To be completed by student and shared with medical provider

Last Name	First Name	Middle Name
		Date of birth (MM/DD/YY)
Student ID number		

Please answer the following questions:

Have you ever had a positive TB skin test? Yes No

Have you ever had close contact with anyone who was sick with TB? Yes No

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years?
 (If yes, please CIRCLE the country) Yes No

Have you ever traveled* to/in one or more of the countries listed below?
 (If yes, please CHECK the country/ies) Yes No

Have you ever been vaccinated with BCG? Yes No

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Afghanistan	Congo	Kazakhstan	Namibia	Sri Lanka
Algeria	Côte d'Ivoire	Kenya	Nepal	Sudan
Angola	Croatia	Kiribati	Nicaragua	Suriname
Argentina	Democratic People's	Kuwait	Niger	Swaziland
Armenia	Republic of Korea	Kyrgyzstan	Nigeria Pakistan	Syrian Arab Republic
Azerbaijan	Democratic Republic	Lao People's	Palau	Tajikistan
Bahrain	of the Congo	Democratic	Panama	Thailand
Bangladesh	Djibouti	Republic	Papua New Guinea	The former Yugoslav
Belarus	Dominican Republic	Latvia	Paraguay	Republic
Belize	Ecuador	Lesotho	Peru	of Macedonia
Benin	El Salvador	Liberia	Philippines	Timor-Leste
Bhutan	Equatorial Guinea	Libyan Arab	Poland	Togo
Bolivia (Plurinational	Eritrea	Jamahiriya	Portugal	Tonga
State of)	Estonia	Lithuania	Qatar	Trinidad and Tobago
Bosnia and	Ethiopia	Madagascar	Republic of Korea	Tunisia
Herzegovina	French Polynesia	Malawi	Republic of Moldova	Turkey
Botswana	Gabon	Malaysia	Romania	Turkmenistan
Brazil	Gambia	Maldives	Russian Federation	Tuvalu
Brunei Darussalam	Georgia	Mali	Rwanda	Uganda
Bulgaria	Ghana	Marshall Islands	Saint Vincent and the	Ukraine
Burkina Faso	Guam	Mauritania	Grenadines	United Republic of Tanzania
Burundi	Guatemala	Mauritius	Sao Tome and Principe	Uruguay
Cambodia	Guinea	Micronesia	Senegal	Uzbekistan
Cameroon	Guinea-Bissau	(Federated States	Serbia	Vanuatu
Cape Verde	Guyana	of)	Seychelles	Venezuela (Bolivarian
Central African	Haiti	Mongolia	Sierra Leone	Republic of)
Republic	Honduras	Montenegro	Singapore	Viet Nam
Chad	India	Morocco	Solomon Islands	Yemen
China	Indonesia	Mozambique	Somalia	Zambia
Colombia	Iraq	Myanmar	South Africa	Zimbabwe
Comoros	Japan			

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2009. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://apps.who.int/ghodata/?vid=510>

If the answer is YES to any of the above questions, Elon University requires that a health care provider complete a tuberculosis risk assessment (to be completed within 6 months prior to the start of classes).

If the answer to all of the above questions is NO, no further testing or further action is required.

5. Plan of care

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF- α antagonist
- Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker, or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease