Elon University
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. University Policy and State Regulations require that all new students, credit bank students, and those taking a semester course submit a health form.

North Carolina Public Health law requires proof of immunization to protect you and others while you are attending Elon University. You should review the following regulations and recommendations as they apply to you.

Please complete all forms accurately with completed dates including month, day, and year, along with the types of vaccines. This information can be obtained from your physician or health department. 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 acceptable.** Copies of the health form can be found at http://www.elon.edu/e-web/students/health_services/

Students attending Fall Semester, health forms are due July 1st

Students attending Spring Semester, health forms are due February 1st

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

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

CLASS YOU ARE ENTERING (circle): FR. SO. JR. SR

PREVIOUSLY ENROLLED HERE ❑ YES ❑ NO ____YR.
PREVIOUSLY A PATIENT HERE ❑ YES ❑ NO

SEMESTER ENTERING (circle): fall winter spring sumr. 1 sumr 2 yr. 20____

HOSPITAL/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: (Immediate family only)

	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		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 or hospitalized for emotional/psychological concerns? yes ☐ no ☐ Are you presently on medication? yes ☐ no ☐			

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.

______________________________ ______________________________

Signature of Student Date

______________________________ ______________________________

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

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

UNDERGRADUATE 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 or 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**	**Hepatitis B**
3[1]	2[2]	2[3]	1[4]	3

Footnote 1: DTP (Diphtheria, Tetanus, Pertussis), DTaP (Diphtheria, Tetanus, acellular Pertussis), Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, Pertussis): 3 doses of tetanus/diphtheria toxoid of which one must have been within the past 10 years.

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.

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 of 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.

IMMUNIZATION RECORD

Part I

Name ____________________ ____________________ ____________________
(Last) (First) (Middle)

Date of Birth __/____/____ SS# ______-_______-______ Part-time ______ Full-time______

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 or Tdap in the last ten years.

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___

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

M.M.R. (Measles, Mumps, Rubella) (Two doses required.) **1st dose must be given 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.)

TUBERCULIN TEST

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

If positive skin test (over 09mm in duration): Date of chest x-ray ____/____/____
*If BCG was given over 2 years ago, tuberculin skin test is required.

Hepatitis B **Series must be started before attending Elon.**

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

Meningococcal (A, C, Y, W-135) HIGHLY RECOMMENDED BUT NOT REQUIRED
Date Given ____/____/____

Not Required:

Hepatitis A . . . . #1 ___/___/___ #2 ___/___/___

Varicella . . . . #1 ___/___/___ #2 ___/___/___

Gardasil (HPV human papillomavirus) . . . .#1 ___/___/___, #2 ___/___/___, #3 ___/___/___

Yellow Fever . . . . . . ___/___/___ Typhoid . . . . .IM ___/___/___ Oral ___/___/___

Polio.........OPV #1 ___/___/___ #2 ___/___/___ #3____/___/___ #4____/____/___

IPV #1 ___/___/___ #2___/___/____ #3____/___/___ #4___/____/___

HEALTH CARE PROVIDER

Name (print) ________________________________ Address ________________________________

Signature__________________________ Phone (_____)_____________ Fax (____)____________

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