ELON UNIVERSITY

REQUIRED UNDERGRADUATE 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 **UNDERGRADUATE** students

Complete
Initials

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

UNDERGRADUATE

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	Previously enrolled here? ❑ **YES** ❑ **NO** _____**YR.**	**SEMESTER ENTERING (circle):**
(circle) FR. SO. JR. SR.	Previously a patient here? ❑ **YES** ❑ **NO**	fall winter spring sumr1 sumr2 year 20_____

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.

☐_____ ☐_____

☐_____ ☐_____

☐_____ ☐_____

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

Footnote[1] - 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.

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] - An individual attending school who has reached his or her 18th birthday is not required to receive polio vaccine.

Footnote[3] - 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.

Footnote[4] - 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.

Footnote[5] - 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.

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

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.

Tuberculosis (TB) Risk Assessment

To be completed by health care provider in clinical setting

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

Persons with any of the following are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

Risk Factors:	
Recent close contact with someone with infectious TB disease	❑ Yes ❑ No
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)	❑ Yes ❑ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	❑ Yes ❑ No
HIV/AIDS	❑ Yes ❑ No
Organ transplant recipient	❑ Yes ❑ No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-α antagonist	❑ Yes ❑ No
History of illicit drug use	❑ Yes ❑ No

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

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____
If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive____ negative____

COMPLETE IF TWO STEP TST REQUIRED:

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive____ negative____

3. Interferon Gamma Release Assay (IGRA)
Date Obtained: ____/___/___ (M D Y) (specify method) QFT-G QFT-GIT T-Spot other_____
Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/___/___ (M D Y) (specify method) QFT-G QFT-GIT T-Spot other_____
Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ (M D Y) Result: normal____ abnormal_____

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