



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.

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. At that time, students will be disenrolled from classes until their 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 acceptable. **Please keep a copy of the form for your records.**

Please review the immunization requirements thoroughly. Transfer students need a physical and a tuberculin skin test (PPD) and the results **within the past year of starting Elon.**

COMPLETED HEALTH FORMS ARE DUE 30 DAYS BEFORE ENROLLMENT.

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 www.elon.edu/students/health and in our brochure.

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

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



Dear Parent,

Outbreaks of meningitis have increased on college campuses in recent years. Reasons for the increased incidence of meningitis are not completely clear however studies suggest that outbreaks may occur because students live and work in close proximity to each other in dormitories and classrooms. The student's lifestyle may also contribute to risk. Exposure to active and passive smoking, alcohol consumption and bar patronage (with or without alcohol consumption) all increase the chance of contracting meningitis from an infected person.

ABOUT THE VACCINE: The vaccine has shown to be 85-100% effective in serogroups A, C, Y and W-135. At this time there is no vaccine against serogroup B. The vaccine is very safe and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the injection site and may last up to two days.

WHO RECOMMENDS THIS VACCINE: As of February 10th, 2005, the Advisory Committee on Immunization Practices (ACIP) of the United States Centers for Disease Control and Prevention (CDC), with the support for the American College Health Association (ACHA) Vaccine-Preventable Diseases Task Force recommends that undergraduate college students, particularly freshman who live in or plan to live in dormitories or resident halls, consider getting the vaccine to reduce their risk for meningococcal disease. The new recommendation is an about-face from previous policy and was sparked largely by a new vaccine. The new vaccine is effective for more than eight years, while the old vaccine lasted just three to five years. The old vaccine also didn't prevent people from being carriers of the bacteria; the new vaccine does.

WHO SHOULD NOT GET THE VACCINE: Students with an acute illness at the time the vaccine is given, pregnant women, students allergic to thimerosal (preservative) or other components of the vaccine.

WHAT THE PARENT SHOULD DO: Encourage your son or daughter to get immunized. At the time of immunization your son or daughter will receive an Immunization Consent Form copy confirming that the immunization was administered. Review the frequently asked questions with your son or daughter.

FREQUENTLY ASKED QUESTIONS

MENINGITIS:

What is meningococcal meningitis?

Meningococcal meningitis is a serious bacterial infection that causes inflammation of the membranes surrounding the brain and spinal cord.

What are the symptoms?

Symptoms are similar to those of influenza. Fever, severe headache, stiff neck, rash, nausea, vomiting and lethargy may occur. The infection can lead to permanent disabilities and even death.

How is the disease spread?

The infection is spread by direct contact with infected individuals (for example, sharing a glass or cigarette, or kissing). The infection is also spread through the air by respiratory secretions by coughing or sneezing.

How common is meningitis?

Meningitis strikes about 3,000 Americans each year and is responsible for approximately 300 deaths annually. 100 to 125 cases of meningitis disease occur annually on college campuses and 5 to 15 students die as a result. Thankfully there have been no outbreaks here at Elon University.

Who is at risk for meningitis?

A rising outbreak has occurred in schools, universities, and other organization based settings, according to the American College Health Association.

Why are college students at greater risk for meningitis?

College students seem to be more susceptible because they live and work in close proximity to each other in dormitories. Behavioral and social aspects of college life appear to be risk factors; smoking, exposure to second hand smoke, excessive alcohol consumption, and bar patronage all increase the chances of contracting meningitis from an individual.

How can college students protect themselves from getting meningitis?

Vaccination can provide protection against four out of five strains of meningitis. These four strains cause nearly 70% of meningococcal meningitis cases on college campuses.

Why should college students receive the meningitis vaccine?

Vaccination had been delayed in the past until an outbreak occurred. Results of two CDC studies conducted in 1998 identified a higher risk among freshman dormitory residents. The studies resulted in recommendations by the Advisory Committee on Immunization Practices (ACIP) and the American College Health Association (ACHA); the recommendations state that vaccination should be provided to those college students that wish to reduce their risk of contracting meningitis.

What are the side effects of the vaccine?

Side effects are mild and infrequent; they consist of redness and swelling at the injection site and may last up to two days. The meningitis vaccine should not be given to anyone that is ill (acute illness) or running a fever. The vaccine should not be given to anyone allergic to thimerosal or any other component of the vaccine. If the student is pregnant, she should consult with her private physician regarding the risks and benefits of immunization.

How effective is the vaccine, and how long does it offers protection?

The vaccine has been shown to create protective antibodies against meningitis in 90% of the population studied. Meningitis vaccine may not protect 100% of susceptible individuals. Protection from the vaccine lasts for more than eight years.

What can college students do to reduce the risk of contracting meningitis?

Eating a balanced diet, getting adequate sleep and exercise, avoiding cigarettes and excessive use of alcohol will help to maximize the body's own immune system.



What Parents Need To Know About The Flu

About the Flu:

Influenza (commonly called “the flu”) is caused by the influenza virus, which infects the respiratory tract (nose, throat, lungs). It can cause mild to severe illness, and at times can lead to death. In the United States, it is estimated that 10 percent to 20 percent of people get the flu each year: an average of 200,000 people are hospitalized for flu-related complications and 36,000 Americans die each year from complications of the flu.

Five hundred out of 100,000 children with high-risk conditions (such as heart disease or asthma) and 100 out of 100,000 otherwise healthy children aged 0 to 4 years who are infected with the flu will be hospitalized for complications each season.

Symptoms of Flu:

Symptoms of flu include fever (usually high), headache, tiredness (can be extreme), dry cough, sore throat, runny or stuffy nose, and muscle aches. Other symptoms, such as nausea vomiting, and diarrhea, are much more common among children than adults.

Who is at Greatest Risk?

Children at greatest risk for being seriously harmed by flu include those who live in long-term care facilities or have the following medical conditions:

- heart disease;
- lung disease, including asthma;
- kidney disease;
- metabolic disease, including diabetes;
- anemia or other blood disorder;
- weakened immune systems (including HIV infection); and
- condition causing them to receive long-term aspirin therapy (and therefore a higher chance of developing Reye syndrome if infected with the flu).

In addition, healthy children ages 6 to 59 months are also encouraged to get the vaccine because the flu can lead to higher rates of hospitalization.

About the Flu Vaccine:

The flu vaccine prevents the flu, a common and highly contagious infection that can cause serious illness, and even death, in young children, older adults, and certain vulnerable people of all ages. Flu immunization is encouraged because the flu can lead to other problems including pneumonia, inflammation of the heart, and inflammation of the lungs. Healthy children younger than five years of age are more likely than adults to be hospitalized for complications from the flu. The vaccine protects between 45 percent and 90 percent of healthy children from getting the flu. Studies have shown that the older and healthier children are when they get a flu shot, the more likely they will be protected. Flu vaccination has also been shown to decrease middle ear infections among young children by about 30 percent.

When is the Best Time to Immunize Against the Flu?

The peak season for the flu in the United States is November through April. The ideal time for children to get a flu shot is in October — especially for children under nine years of age who, if they have never had a flu shot before, need a second dose at least one month after their first flu shot, preferably before December. Elon University offers the flu shot for free on campus.

Vaccine Reactions

The majority of children who receive the vaccine (about 80 percent) will have no side effects. Of those children who have a side effect, most will have only a mild local reaction.

- Mild reactions include soreness or redness where the shot was given.
- Children may have fever, chills, or a general sense of feeling unwell that lasts for one to two days.
- Aspirin-free pain reliever can be used to reduce fever and soreness.

In very rare cases (far less than 1 out of 10,000), vaccinated children can have a serious allergic reaction.

- Children who have an allergy to eggs (which are used in making the vaccine) or any component of the flu vaccine are at greater risk for a serious allergic reaction.

Your child's chance of being harmed by the flu is far greater than the chance of being harmed by the vaccine. Immunizations are one of the most important ways parents can protect their children against serious diseases.

Can My Child Still Get the Flu if He/She Has Been Given the Vaccine?

Yes. Since no vaccine is 100 percent effective, there will always be some immunized people who get the disease. Also, the flu virus changes every year, so there is no way to know exactly which strains of the flu must be in the vaccine to provide complete immunity. The vaccine protects between 45 percent and 90 percent of healthy children from getting the flu, depending on how closely the vaccine strain matches the strain circulating in the community. If a child or adult gets the flu after having received the vaccine, it is usually a much milder case of the disease.

Can My Child Get the Flu from the Flu Shot?

No. The flu vaccine that is licensed and currently available in the United States is made of killed flu viruses and cannot cause infection. Because the flu shot is given in the fall and winter when other common viruses are causing flu-like symptoms, some people will develop illnesses in the weeks after receiving a flu shot. These illnesses are generally not caused by the flu, but rather by an infection from another virus.

What Are Some Good Health Habits to Follow?

The following steps may help prevent the spread of respiratory illnesses like flu:

- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your mouth and nose with a tissue when coughing or sneezing.
- Wash your hands to protect you from germs.
- Avoid touching your eyes, nose or mouth.

Who Can I Talk to About Getting My Child Vaccinated Against the Flu?

Talk to your pediatrician or physician about getting your child immunized against the flu this year. Parents can also talk to someone in their local health department's immunization program about getting the vaccine as well. Remember, the best time to immunize against the flu is in the fall, particularly in October or November. However, it is not too late to get vaccinated in December or later.

Other Resources

- www.immunizenc.com | Immunization Branch, N.C. Department of Health and Human Services
- www.cdc.gov/flu | Centers for Disease Control and Prevention Flu Home Page
- www.immunizationinfo.org | National Network for Immunization Information

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

TRANSFER 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.
- Blood titers done to document immunity must be accompanied by a lab report for completion of immunization record.

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: 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. A dose of Tdap vaccine is not required for any student over the age of 64.

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 matriculation (chest x-ray report required if test is positive) Tine test not accepted.
- Hepatitis B series – first dose required before matriculation.
- Physical within the twelve months preceding matriculation.

Comp.
Inits.

R. N. Ellington Health Center

Elon University, CB 2040

Elon, NC 27244

Phone: 336-278-7230 Fax: 336-538-6506

TRANSFER

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:

	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)			

FAMILY & 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 _____

IMMUNIZATION RECORD

Part I

Name _____
(Last) (First) (Middle)

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

M.M.R. (Measles, Mumps, Rubella) (Two doses required.)

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 (PPD) Must be within one year prior to matriculation.(July 1)

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 given.

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 ____/____/____

Gardasil (HPV human papilloma virus) #1 ____/____/____, #2 ____/____/____, #3 ____/____/____

Varicella #1 ____/____/____ #2 ____/____/____

Typhoid IM ____/____/____ Oral ____/____/____

Yellow Fever ____/____/____

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

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

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

Vision: Corrected Right 20/____ Left 20/____ Uncorrected Right 20/____ Left 20/____				Urinalysis: (if indicated) Sugar _____ Albumin _____ Micro _____			
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 # _____