



Student Health Services
1533 S. Main Street (27127), P.O. Box 12189
Winston-Salem, North Carolina 27117-2189



PLACE
STAMP
HERE

IMPORTANT

Welcome to UNCSA! We look forward to serving your health care needs. A complete list of the services we offer is located on the web: http://www.uncsa.edu/studentlife/student_health.htm
A copy of this form and other useful health forms is available: <http://www.uncsa.edu/students/forms.htm>
Please use the checklist below to make sure you have completed this form in its entirety. North Carolina laws and University of North Carolina School of Arts policy require documentation of immunization and completion of this form. Failure to comply will result in administrative withdrawal from school and/or a delay in your registration.

Immunizations:

- Complete the immunization form carefully. Obtain all needed immunizations before submitting this form. Check the “Guidelines for Completing Immunization Record” to make sure you have received the required immunizations. For most students 3DTP shots; 2 MMR shots; 3 doses of Polio; and a Tetanus shot within the past 10 years are required.
- Persons born on/after 7/1/94 are required to receive a HepB vaccine series.
- The meningitis vaccine is strongly recommended (*please document this vaccine also*).
- Documentation of all immunizations requires **month, date, and year.**
- Medical and/or religious exemptions from immunizations should be verified by a written statement from you and/or your doctor.
- If you have left the United States in the past year a tuberculosis skin test is required.
- Make sure your name is on the top of the immunization form.
- Have your health care provider **sign and date** the immunization sheet (two signatures required).

Physical examination

- All newly admitted, transfer, international, and readmitted UNCSA students must complete the physical exam prior to registration. Those transferring from high school at UNCSA to college at UNCSA or from college to graduate school must also complete this form with a new physical.
- Please note that **all dancers are required to complete the green pre-participation physical form included in this booklet in addition to the blue physical form.**
- The physical examination must be within 6 months of your date of enrollment for those attending the school year. For summer school students, a physical within the past year is acceptable.
- Put your name on every sheet of the form.
- If you are under 18 years of age the “statement by student/parent/guardian” must be signed by both parent/guardian and student.
- Please include several daytime emergency phone numbers that we may contact in an emergency.

Insurance

- All students are required to have a major medical insurance policy.
- Attach a front and back copy of any health insurance and/or prescription cards.
- Details about the University selected Pearce & Pearce Insurance will be sent with your tuition bill. Your account will be charged for this policy unless you waive/opt out by going to www.studentinsurance.com. A copy of the policy is also available on the web: <http://www.uncsa.edu/students/forms.htm>.

*****KEEP A COPY OF THESE COMPLETED FORMS FOR YOUR RECORDS*****

DO NOT MAIL THE FORM TO ADMISSIONS OR YOUR ARTS SCHOOL, MAIL THIS FORM TO:

Student Health Services

University of North Carolina School of the Arts

1533 S. Main Street Winston-Salem, NC 27127

PHONE: 336-770-3288

FAX: 336-770-1492

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Be certain that your Name, Date of Birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and the year.

Please Keep a Copy for Your Records.

Acceptable Records of your Immunizations may be obtained from any of the following:

- High School Records – These may contain some, but not all of your immunization information. **Your immunization records do not transfer automatically. You must request a copy.**
- Personal Shot Records – Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department
- Military Records of WHO (World Health Organization Documents) - These records may not contain all of the required immunizations.
- Previous College or University – **Your immunization records do not transfer automatically. You must request a copy.**

SECTION A: COLLEGE/UNIVERSITY VACCINES AND NUMBER OF DOSES REQUIRED (For further information: <http://www.immunizenc.com/college.htm>)

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.**

VACCINE REQUIRED <small>(REVIEW ALL FOOTNOTES BELOW)</small>	Diphtheria, Tetanus, and/or Pertussis ¹	Polio ²	Measles ³	Mumps ⁴	Rubella ⁵	Hepatitis B ⁶
DOSES REQUIRED	3	3	2	2	1	3

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 with the past 10 years.

FOOTNOTE ² – An individual attending school who has attained 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: Physician diagnosis of disease prior to January 1, 1994; An individual who has been documented by serological testing to have a protective antibody titer against measles and **submits the lab report**; 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 and **submits the lab report**; 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 and **submits the lab report**.

FOOTNOTE ⁶ Hepatitis B vaccine is not required if any of the following occur: Born before July 1, 1994

INTERNATIONAL STUDENTS and/or non-US Citizens: Vaccines are required as noted above. Additionally, these students are required to have a TB skin test (PPD or TST) that has been administered and read at an appropriate medical facility within 12 months prior to the first day of class. (Chest x-ray required if test is positive).

SECTION B: These vaccines are RECOMMENDED.

North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Attached to this form is information regarding meningococcal disease, including recommendations from the Centers for Disease Control of the U.S. Public Health Service. Please record on the front of this form, whether or not you have received the meningococcal vaccine. If, yes, please note the month, day, and year of the vaccination.

FORM UPDATED 3/2010

SECTION C: These vaccines are optional.

Dear Student and/or Parent:

As the health services director at the University of North Carolina School of the Arts, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and recommendations from the Centers for Disease Control and Prevention (CDC). On October 20, 1999, the CDC's Advisory Committee on Immunization Practices (ACIP) voted to recommend that college students, particularly freshmen living in dormitories and residence halls, be educated about meningitis and the benefits of vaccination. The panel based its recommendation on recent studies showing that college students, particularly freshmen living in dormitories, have a six-fold increased risk for meningitis. The recommendation further states that information about the disease and vaccination is appropriate for other undergraduate and residential high school students who also wish to reduce their risk for the disease.

The ACIP has expanded its recommendations for meningococcal vaccine recipients to include adolescents. The newer formula of meningococcal vaccine, meningococcal conjugated vaccine (MCV-4) has been recommended for routine use in all adolescents aged 11-12 years old. For those adolescents not yet having received the vaccine, prompt vaccination is recommended. It is the goal of the ACIP that within 3 years there will be routine vaccination of all adolescents beginning at age 11 years old. This approach is the most effective strategy to reduce meningococcal disease incidence in adolescence and your adulthood.

Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. All students living in dormitories are at a higher risk for meningococcal disease compared to other people the same age. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease.

Meningococcal disease is caused by bacteria that infect the linings of the brain and spinal cord, causing serious illness. The disease often begins with symptoms that can be mistaken for common illnesses such as the flu. Meningococcal disease is particularly dangerous because it progresses rapidly and can kill within hours. Every year in the United States up to 2800 people get meningococcal disease. Ten to 14 percent of the people with this disease die, and 11-19 percent of survivors have permanent disabilities such as mental retardation, hearing loss and loss of limbs. A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States — types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students.

I encourage you to learn more about meningitis and the vaccine. For more information, please feel free to contact our health service and/or consult your physician. This vaccine is available at the Wellness Center should you be unable to obtain it prior to arriving at UNCSA.

You can also find information about the disease at the following web sites.

Center for Disease Control - http://www.cdc.gov/ncidod/diseases/submenus/sub_meningitis.htm

The American College Health Association Web site - WWW.ACHA.ORG

Sincerely,



Ann Potter
FNP, MSN
Director Health Services

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

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)

Permanent Address	City	State	Zip Code	Area Code/Phone Number
Height _____	Weight _____	TPR _____ / _____ / _____	BP _____ / _____	

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 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 _____

Physician comments and review of history: _____

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

Please also review and sign immunization record.

Date received at UNCSCA:	Entered in Medicat:	Imm	Personal
REPORT OF MEDICAL HISTORY (Please print in black ink) To be completed by student			

LAST NAME (print)	FIRST NAME	MIDDLE/MAIDEN NAME	*SOCIAL SECURITY NUMBER (optional)
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PERMANENT ADDRESS	CITY	STATE	ZIP CODE	AREA CODE/PHONE NUMBER	STUDENT CELLPHONE NUMBER
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DATE OF BIRTH (mo/day/yr)	E MAIL _____	
CLASS YOU ARE ENTERING (circle)	PREVIOUSLY ENROLLED HERE <input type="checkbox"/> YES <input type="checkbox"/> NO	ENTERING (circle all): FALL WINTER SPRING SUMMER
High school 8 9 10 11 12	IF YES, DATE: _____	DANCE DRAMA MUSIC FILM D&P/VA YEAR _____
College 1 2 3 4 5 6		

Emergency Contact --Name: _____ Relationship: _____ Phone #: _____

Emergency Contact --Name: _____ Relationship: _____ Phone #: _____

*******ALL STUDENTS ARE REQUIRED TO HAVE MAJOR MEDICAL HEALTH INSURANCE*******

Details about the University selected Pearce & Pearce Insurance is available @ www.studentinsurance.com
 Your account will be charged for this policy unless you opt/waive out by going to www.studentinsurance.com

I will purchase the Pearce&Pearce Insurance plan: **YES** **NO**

I have chosen to waive out and have attached copies of both my Insurance and Rx/Prescription Card (front and back) **YES** **NO**

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.

FAMILY & PERSONAL HEALTH 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		Y	N	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 need glasses				Bipolar			
Chronic cough				Paralysis				Bone, joint, or other deformity				Blood transfusion			
Head or neck radiation treatments				Depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry or anxiety or obsession				Recurrent back pain				Illegal Drug use			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Eating disorder			
Thyroid trouble				Intestinal trouble				Back injury				Smoke			
Diabetes				Treatment for ADD or ADHD				Broken bone (specify)				Regularly exercise			
Serious skin disease				Frequent vomiting				Kidney infection				Wear seat belt			
Mononucleosis				Gall bladder trouble or gallstones				Bladder infection				Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

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

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED (Please print in black ink) To be completed by student

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).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin, ibuprofen, or Tylenol			
Codeine			
Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past year? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION....PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 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 otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional 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 the physicians of the Student Health Service. (Not applicable to community colleges.)
- (C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. (Not applicable to community colleges.)

Signature of Student

Date

Signature of Parent/Guardian, if student under age 18

Date

IMMUNIZATION RECORD

Last Name	First Name	Middle Name	Date of Birth	Student ID#
Please print in black ink. To be completed and signed by physician or clinic. A complete official immunization record from a physician or clinic may be attached to this form. Student to confirm identifying information above is complete before submission.				

SECTION A Required Immunizations	mo/day/year	mo/day/year	mo/day/year	mo/day/year	
* DTP or Td or Tdap	(#1)	(#2)	(#3)	(#4)	
*Tdap booster (If due update after 7/2008)					
* Td booster					
* Polio					
* MMR (after first birthday)					
* Measles/ Rubella (MR) (after first birthday)					
* Measles (after first birthday)					** Disease Date Titer Date & Result
* Mumps					Not Acceptable *** Disease Date Titer Date & Result
* Rubella					Not Acceptable *** Disease Date Titer Date & Result
* Hepatitis B (Required if born 7/1/94 or after)	(#1)	(#2)	(#3)		

SECTION B Recommended Immunizations

The following immunizations are recommended for all students.

Meningococcal vaccine: No () Yes() Which vaccine? Menactra () Menomune () Date given:

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
* Hepatitis B series only				****anti-HBs Date & Result
* Hepatitis A/B combination series				
*Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
* Tuberculin Skin Test (PPD) Date read (within 12 months) Report result in mm induration				
Chest X-Ray, if positive PPD Date Results				
Treatment if applicable Date				

SECTION C Optional Immunizations	mo/day/year	mo/day/year	mo/day/year
* Haemophilus influenzae type b			
* Pneumococcal			
* Hepatitis A series only			
* HPV (Gardasil)			
* Other			

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner

Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Phone number

Office Address

City

State

Zip Code

** Must repeat Rubella (measles) vaccine if received more than 4 days 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 the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

**** Lab Report must be submitted.