

# **ELIZABETH CITY STATE UNIVERSITY**

## **STUDENT HEALTH SERVICES**

1704 Weeksville Road \* Campus Box 885  
Elizabeth City, N.C. 27909



Main Number  
252-335-3267

Fax  
252-335-3269

**Congratulations on your acceptance to the Elizabeth City State University and welcome to Student Health Services. North Carolina Law (General Statute 130A-152) requires that all students entering a college or university must present a “certificate of immunization” on or before the first day of registration.**

**Who needs to complete this form?**

- All students taking more than four credit hours on the university campus must provide documentation of having received all required immunizations and comply with university policies and procedures for submission of health forms.

**When is this form due?**

- This form must be received and completed in its entirety **NO LATER THAN JULY 15<sup>TH</sup> FOR FALL ENROLLMENT, DECEMBER 4<sup>TH</sup> FOR SPRING ENROLLMENT, AND MAY 1<sup>ST</sup> FOR SUMMER ENROLLMENT.**
- Please complete this attached form and mail to Student Health Services in the enclosed self addressed envelope.

**Exceptions:**

- ECSU does not require a physical examination.
- ECSU does not require a TB skin test except for international students from Non-European countries.
- Medical Exemptions from immunizations must be requested and signed by a physician.

**Where can you get immunization information?**

- Your Physician
- Your Local Health Department
- ECSU Student Health Services (For re-entering students only)

**OTHER IMPORTANT INFORMATION**

- Pay careful attention to the Guidelines for Completing Immunization Record.
- Copies of immunization cards may be submitted. These copies must be in their entirety with the name of the clinic/health department and/or physician signatures included.
- The Family and Personal Health Record **MUST BE SIGNED BY THE STUDENT AND/OR THE PARENT, IF THE STUDENT IS A MINOR.**

**Please note that if these immunization requirements are not met, dismissal from school is mandatory under North Carolina law!**

**REPORT OF MEDICAL HISTORY**

LAST NAME (print) \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE/MAIDEN NAME \_\_\_\_\_ PERSONAL ID# (PID) \_\_\_\_\_

PERMANENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ COUNTRY \_\_\_\_\_ AREA CODE/PHONE NUMBER \_\_\_\_\_

DATE OF BIRTH (mm/dd/yyyy) \_\_\_\_\_ GENDER  M  F  T MARITAL STATUS  S  M

ECSU EMAIL \_\_\_\_\_ CELL PHONE NUMBER: \_\_\_\_\_

Year Entering: \_\_\_\_\_ Semester Entering:  Fall  Spring  Summer 1  Summer 2

Class Entering:  FR  SO  JR  SR  GRAD

Previously enrolled at another University?  No  Yes If Yes, Date first enrolled: \_\_\_\_\_

If previously enrolled at ECSU, Dates of Enrollment: \_\_\_\_\_

International Student:  No  Yes - Country of Origin \_\_\_\_\_ Primary Language: \_\_\_\_\_

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ AREA CODE/PHONE NUMBER \_\_\_\_\_

**FAMILY & PERSONAL HEALTH HISTORY**

Has any person, related by blood, had any of the following?

	Yes	No	Unknown		Yes	No	Unknown		Yes	No	Unknown
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			

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

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				Protein or blood in urine			
Chicken Pox				Allergy injection therapy				Ulcerative colitis, Crohn's disease				Hearing loss			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Frequent Sinus Infections			
Pain or pressure in chest				Concussion or traumatic brain injury				Hernia				Severe menstrual cramps			
Shortness of breath				Frequent or severe headache				Easy fatigability				Sexually trans. Infections (STI)			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Irregular periods			
Pneumonia				ADD/ADHD				Eye trouble besides need glasses				Blood transfusion			
Chronic cough				Paralysis				Bone, joint, or other deformity				Drug use			
Head or neck radiation treatments				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain Or back injury				Anorexia			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Bulimia			
Thyroid trouble (specify)				Intestinal trouble				Broken Bones				Tobacco Use			
Diabetes				Pilonidal cyst				Kidney stones				Regularly exercise			
Serious skin disease				Frequent vomiting				Kidney/Bladder infection				Other (specify):			
Mononucleosis				Gall bladder trouble or gallstones				Epilepsy							

Medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) used:

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_ Name \_\_\_\_\_ Use \_\_\_\_\_ Dosage \_\_\_\_\_

<b>Adverse Reactions to:</b>	No	Yes	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine			
Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

<b>Other Health Issues:</b>	No	Yes	Explanation
Do you have any conditions or disabilities that limit your physical activities?			
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 six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

**STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):**

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 (student) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

I hereby authorize any medical treatment for myself (student) that may be advised or recommended by Student Health Services.

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.

Registered students taking six (6) or more credit hours are required to purchase the Student Health Insurance Plan, with the following exceptions: distance education students (students taking off campus and Internet only courses) and students who submit evidence of equivalent coverage satisfactory to the policyholder may waive coverage. Visit [www.bcsnc.com/uncp](http://www.bcsnc.com/uncp) to waive out of the University sponsored plan. Waiver deadlines vary each semester. Deadline information can be found at [www.bcsnc.com](http://www.bcsnc.com).

\_\_\_\_\_  
Print Full Name of Student

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian, if student under age 18

\_\_\_\_\_  
Date

## Elizabeth City State University - IMMUNIZATION RECORD

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Last Name
First Name
Middle
Date of Birth ( MM/DD/YYYY )
Personal ID# (PID)

### SECTION A REQUIRED IMMUNIZATIONS

**All students must submit documentation of 3 DTP, Td or Tdap vaccines regardless of age. One MUST be a Tdap.**

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
DTaP/DTP/Td (Diphtheria/Tetanus/Pertussis or Tetanus/Diphtheria Toxoid)				
Tdap booster (All Students MUST show proof of a Tdap booster)				
Polio (3 doses, only required if 17 years of age or younger)				
MMR (Measles, Mumps, Rubella – 2 MMR vaccines required on or after first birthday OR 2 Measles, 2 Mumps and 1 Rubella single doses OR positive Measles, Mumps, Rubella titers)				
Measles (2 required on or after first birthday OR positive titer OR documented disease date)			Disease Date	**Titer Date & Result
Mumps (2 required on or after first birthday OR positive titer)			(Disease Date NOT Accepted)	**Titer Date & Result
Rubella (1 required on or after first birthday OR positive titer)			(Disease Date NOT Accepted)	**Titer Date & Result
Hepatitis B Series (only required if born after July 1, 1994)				<b>Titer NOT Accepted for required Hep B Series</b>

### SECTION B RECOMMENDED IMMUNIZATIONS

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Has the student received the Meningococcal vaccine (Menactra, Menveo, Menomune, MPSV4, MCV4)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, date(s) received - <b>Booster dose recommended at age 16</b>				
Meningococcal B vaccine (Bexsero or Trumenba - Please discuss risks and benefits of this vaccine with your medical provider)				
Hepatitis A				
Hepatitis A/B combination series				
Pneumococcal				
Human Papillomavirus (HPV)	Cervarix			
	Gardasil			
	Gardasil-9			
Varicella (2 doses, documentation of disease date or positive titer)			Disease Date	**Titer Date & Result
Tuberculin Skin Test (TST)	Date Read			
	mm induration	mm	mm	mm
	Date of IGRA (QuantiFERON or T-SPOT) test			**Chest X-ray Date
	Result of IGRA test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	**Chest X-ray Result

\*\* Must attach a copy of all laboratory and Chest X-ray results

Signature and Credentials of Health Care Provider \_\_\_\_\_

Date \_\_\_\_\_

Printed Name and Credentials of Health Care Provider \_\_\_\_\_

Area Code/Phone Number \_\_\_\_\_

Office Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_