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 15TH FOR FALL ENROLLMENT, DECEMBER 4TH FOR SPRING ENROLLMENT, AND MAY 1ST 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!

Elizabeth City State University Student Health Center

Griffin Hall, Suite 300 ▪ CB # 885 ▪ Elizabeth City, NC 27909 Fax: 252-335-3269

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
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Unknown
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Unknown
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
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
High blood pressure			
Chicken Pox			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble (specify)			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion or traumatic brain injury			
Frequent or severe headache			
Dizziness or fainting spells			
ADD/ADHD			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Ulcerative colitis, Crohn's disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain Or back injury			
Neck injury			
Broken Bones			
Kidney stones			
Kidney/Bladder infection			
Epilepsy			

	Yes	No	Year
Protein or blood in urine			
Hearing loss			
Frequent Sinus Infections			
Severe menstrual cramps			
Sexually trans. Infections (STI)			
Irregular periods			
Blood transfusion			
Drug use			
Alcohol use			
Anorexia			
Bulimia			
Tobacco Use			
Regularly exercise			
Other (specify):			

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 _____

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

Other Health Issues:	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.bcbsnc.com/uncp to waive out of the University sponsored plan. Waiver deadlines vary each semester. Deadline information can be found at www.bcbsnc.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

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)				**Titer NOT Accepted for required Hep B Series**

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)? ☐ Yes ☐ No					
If **Yes**, date(s) received - **Booster dose recommended at age 16**					
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	mm
	Date of IGRA (QuantiFERON or T-SPOT) test			**Chest X-ray Date	
	Result of IGRA test	☐Positive ☐Negative	☐Positive ☐Negative	**Chest X-ray Result	☐Positive ☐Negative

** 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** _____