



Student Health Service

Division of Student Life

East Carolina University
Greenville, NC 27858-4353
252-328-6841 office • 252-328-4007 fax
<http://www.ecu.edu/studenthealth>

Appointments
328-6841

Immunizations
328-1093

Wellness Education
328-6794

This Report of Medical History is designed to collect information about your health history and to verify that your immunizations are in compliance with the N.C. immunization law. We will use your address on this form to correspond with you. The information you supply is confidential and will be on file at the Student Health Service to help us provide you with health care while you are a student at ECU.

Please complete and return the Report of Medical History and immunization records according to the following due dates:

May 15th – for students entering in Fall Semester

December 15th – for students entering in Spring Semester

IF IMMUNIZATION REQUIREMENTS ARE NOT MET, DISMISSAL FROM SCHOOL IS MANDATORY UNDER NORTH CAROLINA LAW!

- Verification of immunization records is acceptable **ONLY** with physician, FNP, or PA signature, health department stamp, or a copy of your high school record.
- Medical exemptions from immunizations must be requested and signed by a physician.
- East Carolina University does **NOT** require physical exams.
- Readmit students contact Student Health to reactivate your records.

Other Important Information:

Students can verify their immunization status by going to <https://onestop.ecu.edu/onestop/>, login and click on Admissions Checklist, or by calling (252) 328-6841.

Insurance: It is recommended that students carry health insurance. The ECU Student Health Service offers an affordable insurance plan designed especially for ECU Students. If you would like information, please contact the ECU Student Health Service.

Meningitis: College students, especially freshmen living in residence halls, are at a slightly increased risk for contracting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, and even death within a short period of time. A vaccine is currently available that will decrease, but not completely eliminate a person's risk of acquiring meningococcal meningitis. This element of uncertainty remains because there are five (5) different serotypes and the current vaccine does not offer any protection from serotype B. The vaccine, Menomune, probably protects for 3-5 years, and is extremely safe to use. In 1997 the American College Health Association (ACHA) recommended that students consider vaccination to reduce their risk of contracting meningitis. While the meningitis vaccine is not required for enrollment, the ECU Student Health Service, in accordance with the ACHA, recommends the meningitis vaccine for all freshmen planning to live in the residence halls.



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Accessing Care at the ECU Student Health Service

The staff at the ECU Student Health Service is committed to quality care and providing the best service possible to students. Knowing how to access care can reduce wait time and make for a more efficient and pleasant visit to the Student Health Service.

Available services: Appointments, Pharmacy, Wellness Education, Laboratory, X-Ray, Sports Medicine, allergy Clinic, Urgent Care, Therapeutic Massage, and After Hours Nurse Line.

After Hours Nurse Line: A registered nurse is available after hours, weekends and holidays to triage patient phone calls. Students are directed on how to care for their health problem at home and may be advised to schedule an appointment. For more urgent problems patients are directed to the nearest emergency room or urgent care center. The nurse will assist in determining how urgently the patient should be seen.

Appointments: As with your Doctor's office at home, ***patients are encouraged to schedule an appointment.*** The outpatient clinic is similar to other health care facilities. Students are seen through appointments for general medical care. Appointment visits would include physicals, pap smears, prescription renewals, lab work, follow-ups from previous visits, elective procedures (warts, toenail removals), pregnancy testing gynecological problems, non-acute injuries, skin problems, chronic medical problems, STI screening upper respiratory infections, and non-urgent mental health problems. Also included would be allergy injections, immunizations, nutrition counseling, and health education. *Note: The purchase of medications over the counter or with a prescription from an outside office (carried on the SHS formulary) does not require an appointment and may be handled on a walk-in basis at our Pharmacy.*

Urgent Care: The Urgent Care clinic is available during operating hours for those who need immediate care. Care is provided utilizing a triage system. Urgent Care Triage is staffed by Registered Nurses who assess the patient and determine the urgency in which they need to be seen. Patients needing Urgent Care would include those with acute or disabling injuries or pain, fever greater than 102° F, lacerations or acute wounds, fainting episodes, chest pain, acute emotional problems, acute asthma attacks or difficulty breathing, contagious illness (chickenpox, measles), acute bleeding, seizures or head injuries, burns, sexual assault, poisoning, or acute abdominal pain. ***Note: A provider visit is based on the nurse's assessment and is not guaranteed! Students who present to Urgent Care with problems other than those listed above may be asked to schedule an appointment. Wait time to see the Nurse in Urgent Care varies from 15 minutes to over 2 hours depending on patient volume.***

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.

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (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 year. **Keep a copy for your records.**)

- High School Records – These may contain some, but not all of your immunization information. Contact Student Health for help if needed. **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 or WHO (World Health Organization Documents)
- Previous College or University – **Your immunization records do not transfer automatically. You must request a copy.**

SECTION A:	IMMUNIZATION REQUIREMENTS ACCORDING TO AGE				
STUDENTS 17 YEARS OF AGE AND YOUNGER					
DTP or Td ¹ 3	Polio 3	Measles ² 2	Mumps ⁴ 1	Rubella ⁴ 1	
STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER					
DTP or Td ¹ 3	Polio 0	Measles ^{2,3} 2	Mumps ⁴ 1	Rubella ⁴ 1	
STUDENTS BORN BEFORE 1957					
DTP or Td ¹ 3	Polio 0	Measles 0	Mumps 0	Rubella ⁴ 1	
STUDENTS 50 YEARS OF AGE AND OLDER					
DTP or Td ¹ 3	Polio 0	Measles 0	Mumps 0	Rubella 0	
INTERNATIONAL STUDENTS					
International students are required to have a negative TB skin test (less than 5mm) within the 12 months preceding the first day of classes. Documentation of TB skin test is acceptable only from a United States facility trained in public health or occupational medicine or equivalent US Institution. If the TB skin test is equal to or greater than 5mm, you will be required to schedule a TB evaluation with a SHS provider before your immunization status can be cleared. A chest x-ray may be required. Only chest x-rays performed within the United states will be accepted.					

1. DTP (Diphtheria, Tetanus, Pertussis), Td (Tetanus, Diphtheria): One Td booster within the last ten years
2. Measles: One dose on or after 12 months of age; second at least 30 days later. Must repeat Rubeola (measles) vaccine if received prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.
3. Two measles doses if entering college for the first time after July 1, 1994.
4. One dose on or after 12 months of age. Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

SECTION B:	These vaccines are RECOMMENDED . Some may be required by certain departments. Consult your college or department for specific requirements.
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North Carolina General Statute § 116-260 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Page 2 of this form provides information regarding meningococcal disease, including the Centers for Disease Control of the U.S. Public Health Service website for additional information. Please record on page 6 of this form, whether or not you have received the meningococcal vaccine. If **yes**, please note the month, day, and year of the vaccination.

SECTION C:	These vaccines are OPTIONAL .
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		Banner ID# (BID)
Last Name	First Name	Middle Name
Date of Birth (mo./day/year)		
*Social Security #		
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 may be attached to this form.		

SECTION A REQUIRED IMMUNIZATIONS				
	mo./day/year	mo./day/year	mo./day/year	mo./day/year
	(#1)	(#2)	(#3)	(#4)
• DTP or Td				
• Td booster				
• Polio				
• MMR (after first birthday)				
• MR (after first birthday)				
• Measles (after first birthday)			**Disease Date	****Titer Date & Result
• Mumps			*** (Disease Date NOT Accepted)	****Titer Date & Result
• Rubella			*** (Disease Date NOT Accepted)	****Titer Date & Result

SECTION B RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

	mo./day/year	mo./day/year	mo./day/year	
• Hepatitis B series only				****Titer Date & Result
OR				
• Hepatitis A/B combination series				
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
• Meningococcal				
• Tuberculin (PPD) Test (within 12 months)	Date read 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			
• Other			

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

- * Provision Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.
- ** Must repeat Rubeola (measles) vaccine if received 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.
- **** Attach Lab report

Do Not Write in This Space

REPORT OF MEDICAL HISTORY (Please print in black ink) To be completed by student

LAST NAME (print) _____ FIRST NAME _____ MIDDLE NAME _____ BANNER ID _____ *SOCIAL SECURITY NUMBER _____

PERMANENT ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ AREA CODE/PHONE NUMBER _____

DATE OF BIRTH (mo/day/yr) _____ GENDER M F MARITAL STATUS S M OTHER _____ EMAIL _____

CLASS YOU ARE ENTERING (circle): FR. SO. JR. SR. GRAD. PROF.	PREVIOUSLY ENROLLED HERE IF YES, DATES <input type="checkbox"/> YES <input type="checkbox"/> NO	SEMESTER ENTERING (circle): FALL SPRING
	INTERNATIONAL STUDENT IF YES, COUNTRY OF ORIGIN <input type="checkbox"/> YES <input type="checkbox"/> NO	SUMMER 1 SUMMER 2 OTHER YEAR 20____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) _____ AREA CODE/TELEPHONE NUMBER _____

NAME OF POLICY HOLDER _____ *SOCIAL SECURITY NUMBER _____ EMPLOYER _____

POLICY OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

**If you are enrolled in the BCBS of NC Student Medical Plan, your claims be filed electronically for you. If not, you are responsible for filing your claims

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ AREA CODE/PHONE NUMBER _____

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 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			

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				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				Sexually transmitted			
Chronic cough				Paralysis				Bone, joint, or other deformity				Blood transfusion			
Head or neck radiation treatments				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				Drug use			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Smoke 1+ pack cigarettes/week			
Diabetes				Pilonidal cyst				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 _____

* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

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			
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 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)			

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