Brody School of Medicine – Immunization Record

Name: ______________________________ DOB:__________ Banner ID:______________

The following immunizations are required for all BSOM students. This form must be completed by a licensed healthcare provider and returned prior to August 1st to the Office of Student Affairs, Brody School of Medicine, 600 Moye Blvd. 2S-20, Greenville, NC 27834. **Copies of records are not acceptable.**

- DPT/Tdap: I will provide proof (month/day/year) that I have been vaccinated with THREE doses of DPT (Diphtheria, Tetanus, Pertussis) **AND** that I have been vaccinated with ONE dose of Tdap within the last 10 years (required if 2 years since last Td)
- HEPATATIS B: I will provide proof (month/day/year) that I have been vaccinated with THREE doses of Hep B vaccine **or** serologic evidence of hepatitis B immunity. Series must be started by August 1st.
- MEASLES/MUMPS/RUBELLA: I will provide proof (month/day/year) that I have been vaccinated with TWO doses of MMR vaccine administered at least 28 days apart after my first birthday **or** serologic evidence of immunity.
- POLIO: I will provide proof (month/day/year) that I have been vaccinated with THREE doses of polio vaccine **or** serologic evidence of polio immunity.
- VARICELLA: I will provide proof (month/day/year) that I have been vaccinated with TWO doses of varicella vaccine administered 4-8 weeks apart **or** serologic evidence of varicella immunity. History of disease is not adequate.
- TB SCREENING: Will be administered during Orientation Week in August. If you have had a previously positive PPD please complete page two and provide report of a negative chest x-ray. Prophylaxis therapy is recommended for positive PPD's but not required.

Immunization Documentation	***This form must be completed and signed by a licensed healthcare provider.* Copies of records are NOT acceptable.**			
DPT or Td	#1	#2	#3	
Tdap Booster (within the last 10 years-if 2 years since last Td)	#1			
Polio	#1	#2	#3	or Positive Titer (Polio) Date: Result:
MMR (after first birthday)	#1	#2		or Positive Titer (Measles) Date: Result:
				or Positive Titer (Mumps) Date: Result:
				or Positive Titer (Rubella) Date: Result:
Hepatitis B series	1#	#2	#3	or Positive Titer (Hep B) Date: Result:
Varicella (chicken pox)	#1	#2		or Positive Titer (Varicella) Date: Result:
PPD	Will be administered at August Orientation			
Positive PPD in the past	Complete page 2			

I verify that the above information is true.			
Provider's Name		Phone Number:	
Providers Signature:		Date:	
Address:			

Return signed form to:

Office of Student Affairs
Brody School of Medicine
600 Moye Blvd. 2S-20
Greenville, NC 27834

Brody School of Medicine at East Carolina University

Annual Symptoms Review Subsequent to Positive PPD

STUDENT TO COMPLETE:

Student Info Name____

Banner ID____________________ DOB____________________

PPD Reading Date Placed____________________ Date Read____________________

Induration(mm)____________________ Erythema(mm)____________________

Past History	**Yes**	**No**	**Comments** (dates and/or description)
Previous PPD (pos)			
Previous PPD (neg)			
Previous CXR			
BCG Immunization			
INH Treatment			

Current Symptoms	**Yes**	**No**	**Comments** (dates and/or description)
Persistent Cough			
Productive Cough (blood/sputum)			
Increased Fatigue			
Fever			
Night Sweats			
Weight Loss			
Anorexia			
Recurrent Infections			
Chest Pain			
Dyspnea (short of breath)			

Student's Signature____ Date____________

ASSISTANT DEAN TO COMPLETE:

Recommendation(s)

	Yes	**No**	**Results** (Reviewer please date/initial)
Chest X-ray			
Repeat CXR			
Repeat PPD			
Health Dept Eval			
INH Treatment			
Other			

Assistant Dean's Signature____ Date____________

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

LAST NAME (print) FIRST NAME MIDDLE NAME BANNER ID #

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 ☐ YES ☐ NO
IF YES, DATES _______________
INTERNATIONAL STUDENT ☐ YES ☐ NO
IF YES, COUNTRY OF ORIGIN _______________

SEMESTER ENTERING (circle): FALL SPRING SUMMER 1 SUMMER 2 OTHER YEAR 20____

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

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
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			
Rheumatic fever			
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			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
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			
Rectal 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			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack cigarettes/week			
Regularly exercise			
Wear seat belt			
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.

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Brody School of Medicine
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Greenville, NC 27834

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.)

(D) I acknowledge and understand that I will be automatically billed for the Student Health Insurance Plan if I meet the eligibility requirement criteria each semester. Furthermore, I acknowledge and understand that if I am already covered by a different health insurance plan it is my (the student's) responsibility to complete and submit an online waiver before the beginning of every semester to opt out of the Student Health Insurance Plan and have the charge waived before the deadline expires.

______________________________ _______________

Signature of Student **Date**

______________________________ _______________

Signature of Parent/Guardian, if student under age 18 **Date**