East Carolina University

Student Health Service
Division of Student Affairs
East Carolina University
Greenville, NC 27858-4353

252-328-6841 office
252-328-4007 fax
www.ecu.edu/studenthealth

Administration
328-6904

Appointments
328-6841

Immunizations
328-1093

Health and Nutrition
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://shs.ecu.edu, login and click on Immunization>View History, or by calling (252) 328-6841 option 2.

Insurance: East Carolina University students meeting specific eligibility criteria are required to have health insurance. This is a University of North Carolina General Administration mandate for all 17 UNC System Schools. In response, ECU is offering a cost effective option for our students and parents which will provide high quality health coverage. The provider for this plan is Pearce & Pearce, Inc., Student Insurance Specialists. For more information, please visit http://www.ecu.edu/studenthealth .

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.

<u>Accessing Care at the ECU Student Health Service</u>

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, Fast Track, 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), and 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.*

Fast Track: The Fast Track clinic is available during operating hours for those who need immediate care. Care is provided utilizing a triage system. Fast Track is staffed by Registered Nurses who assess the patient and determine the urgency in which they need to be seen. Patients needing care through Fast Track 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 Fast Track with problems other than those listed above may be asked to schedule an appointment. Wait time to see the Nurse in Fast Track varies from 15 minutes to over 2 hours depending on patient volume.***

GUIDELINES FOR COMPLETEING 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 the vaccine administration must include the month, day, and the year.

Please Keep a copy for Your Records

Acceptable Records of you 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/UNIVSERSITY VACCINES AND NUMBER OF DOSES REQUIRED (For further information: http://www.immunizenc.com/college.htm)

VACCINE REQUIRED (REVIEW ALL FOOTNOTES BELOW)	Diphtheria, Tetanus, and/or Pertussis[1]	Polio[2]	Measles[3]	Mumps[4]	Rubella[5]
DOSES REQUIRED	3	3	2	2	1

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**.

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 one booster dose of tetanus/diphtheria/Pertussis vaccine if a tetanus/diphtheria toxoid and tetanus/diphtheria/Pertussis vaccine has not been administered within 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 fort eh 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**.

INTERNATIONAL STUDENTS and/or non-US Citizens: Vaccines are required as noted above. Additionally, these students are required to have a TB skin test administered with a negative result within the 12 months preceding the first day of classes (chest x-ray required if test is positive).

Exception - International students or United States citizens who are currently living abroad or who have traveled abroad for greater than two months during the year preceding the date of matriculation are required to have a negative Tuberculin Skin Test (TST), less than 5mm, within the 12 months preceding the first day of classes. Documentation of the TST skin test is acceptable only from a United States facility trained in public health or occupational medicine or equivalent US Institution. If the TST skin test is equal to or greater than 5mm, you will be required to schedule a TB evaluation with a CHS provider before your immunization status can be cleared.

SECTION B: These vaccines are RECOMMENDED. Some may be required by certain departments.

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.

SECTION C: These vaccines are optional.

Mail to: STUDENT HEALTH SERVICE
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IMMUNIZATION RECORD

Last Name First Name Middle Name	Date of Birth	Banner 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 or submitted in place of 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

SUBMIT LABORATORY REPORT

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.

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				****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
* 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 Rubeola (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.

FORM UPDATED 5/2011

Do Not Write in This Space

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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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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**