

**Student Medical Form  
for  
North Carolina Community  
College  
System Institutions**

Revised 2003



LAST NAME (print)	FIRST NAME	MIDDLE/MAIDEN NAME	PERSONAL ID#(PID)	*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
	PREVIOUSLY ENROLLED HERE	YES NO		
	IF YES, DATES			
	PREVIOUSLY A PATIENT HERE	YES NO		
	IF YES, DATES			

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.*

	Yes	No	Relationship
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

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			

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

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

	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
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			

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			

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 \_\_\_\_\_

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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)			

**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

**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 Services 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 <sup>1</sup> 3	Polio 3	Measles <sup>2</sup> 2	Mumps <sup>4</sup> 1	Rubella <sup>4</sup> 1
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**STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER**

DTP or Td <sup>1</sup> 3	Polio 0	Measles <sup>2,3</sup> 2	Mumps <sup>4</sup> 1	Rubella <sup>4</sup> 1
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**STUDENTS BORN BEFORE 1957**

DTP or Td <sup>1</sup> 3	Polio 0	Measles 0	Mumps 0	Rubella <sup>4</sup> 1
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**STUDENTS 50 YEARS OF AGE AND OLDER**

DTP or Td <sup>1</sup> 3	Polio 0	Measles 0	Mumps 0	Rubella 0
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**INTERNATIONAL STUDENTS**

Vaccine Required

Vaccines are required according to age (refer to appropriate box). Additionally, International students are required to have a TB skin test and negative result within the 12 months preceding the first day of classes (chest x-ray required if test is positive).

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 even one day 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.

**SECTION C:** These vaccines are **OPTIONAL**.

**I** **MMUNIZATION 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.

			Personal ID# (PID)	
Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	*Social Security #

**SECTION A REQUIRED IMMUNIZATIONS**

	mo./day/year (#1)	mo./day/year (#2)	mo./day/year (#3)	mo./day/year (#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

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
• Hepatitis A/B combination series				
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
• Tuberculin (PPD) Test read (within 12 months) induration	Date mm			
Chest x-ray, if positive PPD	Date Results			
Treatment if applicable	Date			
<b>Meningococcal</b>	Received the meningococcal vaccine?		<b>No</b>	<b>Yes</b>
If <b>Yes</b> , please indicate date(s) vaccine was received (mo./day/year)				

<b>SECTION C OPTIONAL IMMUNIZATIONS</b>			
	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**

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\*\* Must repeat Rubeola (measles) vaccine if received even one day 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

**PHYSICAL EXAMINATION** (Please print in black ink) To be completed and **signed** by physician or clinic

A physical examination is required by **some schools and/or programs** (consult your college or department for specific requirements). **If required**, it must be completed in black ink and signed by a physician or clinic.

Last Name			First Name		Middle Name	Date of Birth (mo/day/year)	*Social Security Number
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Permanent Address				City	State	Zip Code	Area Code/Phone Number
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Height \_\_\_\_\_ Weight \_\_\_\_\_ TPR \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_

<p>IF REQUIRED:</p> <p><u>Vision</u>: Corrected Right 20/ _____ Left 20/ _____          Uncorrected Right 20/ _____ Left 20/ _____          Color Vision _____</p> <p><u>Hearing</u>: (gross) Right _____ Left _____          15 ft. Right _____ Left _____</p>	<p>IF REQUIRED:</p> <p><u>Urinalysis</u>: Sugar: _____ Albumin _____          Micro _____</p> <p><u>Hgb</u> or <u>Hct</u> (if indicated) _____</p> <p><u>STS</u> (may be required by some departments) _____</p> <p>Date _____ Results _____</p> <p>Recommendations _____</p>
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Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

- A. Is there loss or seriously impaired function of any paired organs? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain \_\_\_\_\_
- B. Is student under treatment for any medical or emotional condition? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain \_\_\_\_\_
- C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited \_\_\_\_\_ Limited \_\_\_\_\_  
Explain \_\_\_\_\_
- D. Is student physically and emotionally healthy? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain \_\_\_\_\_

• Only for Students Admitted to a **HEALTH SCIENCES PROGRAM** •

Based on my assessment of this student's physical and emotional health on \_\_\_\_\_, he/she appears able to participate in the activities of a health profession in a clinical setting. Yes \_\_\_\_\_ No \_\_\_\_\_ if no, please explain (Date)

**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**

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