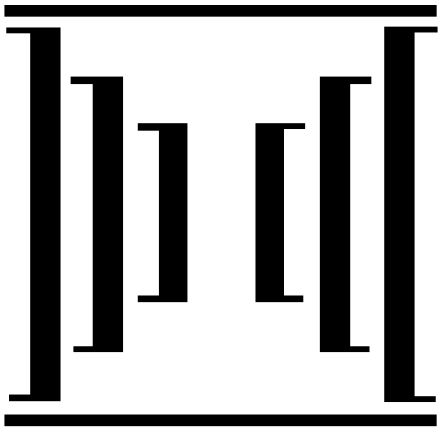
Student Medical Form
for
North Carolina Community College System Institutions



Revised 2003

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

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_____

CLASS YOU ARE ENTERING (circle):
FR. SO. JR. SR. GRAD. PROF.

PREVIOUSLY ENROLLED HERE ☐ YES ☐ NO
IF YES, DATES _____

PREVIOUSLY A PATIENT HERE ☐ YES ☐ NO
IF YES, DATES _____

SEMESTER ENTERING (circle): FALL SPRING
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 | IS THIS AN HMO/PPO/MANAGED CARE PLAN? ☐ YES ☐ NO

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 _____

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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.)**

Signature of Student **Date**

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

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.**

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

SECTION A REQUIRED IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
• DTP or Td	(#1)	(#2)	(#3)	(#4)
• 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.

Meningococcal	Received the meningococcal vaccine? **No** ☐ **Yes** ☐
If **Yes**, please indicate date(s) vaccine was received (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 (PPD) Test Date read				
(within 12 months) 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**

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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

Do Not Write in This Space

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

Permanent Address City State Zip Code	Area Code/Phone Number

Height _____ Weight_____ TPR _____/_____/_____ BP _____/_____

REQUIRED:

Vision: Corrected Right 20/ _____ Left 20/ _____

Uncorrected Right 20/ _____ Left 20/ _____

Color Vision _____

Hearing: (gross) Right _____ Left _____

15 ft. Right _____ Left _____

REQUIRED:

Urinalysis: Sugar:_____ Albumin _____

Micro _____

Hgb or Hct (if indicated) _____

Recommendations _____

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 _____ (Date), he/she appears able to participate in the activities of a health profession in a clinical setting. Yes_____ No_____ if no, please explain _____

_____ _____
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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