

PERSONAL HEALTH FORM AND IMMUNIZATION RECORD

GUIDELINES FOR COMPLETING IMMUNIZATION RECORDS

IMPORTANT – The immunization requirements must be met or, according to NC law, you will be withdrawn from classes without credit.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:

- High School Records – These may contain some, but not all of your immunization information. Contact Student Health for help if needed.
- 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.

(Be certain that your name and Social Security/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.

SECTION A:	IMMUNIZATION REQUIREMENTS ACCORDING TO AGE Vaccines are required according to age. (Refer to appropriate box.)	
<p>I. STUDENTS 17 YEARS OF AGE OR YOUNGER</p> <p>3 DTP (<i>Diphtheria-Tetanus-Pertussis</i>) or Td (<i>Tetanus-Diphtheria</i>) doses. 1 Td (<i>Tetanus-Diphtheria</i>) dose must be within the last 10 years. 3 POLIO (<i>oral</i>) doses. 2 MEASLES* (<i>Rubeola</i>) one dose on or after 12 months of age, the 2nd after 15 months of age. (2MMR doses meet this requirement.) 1 RUBELLA** (<i>German Measles</i>) dose 1 MUMPS**</p>	<p>II. STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER</p> <p>3 DTP (<i>Diphtheria-Tetanus-Pertussis</i>) or Td (<i>Tetanus-Diphtheria</i>) doses. 1 Td (<i>Tetanus-Diphtheria</i>) dose must be within the last 10 years. 2 MEASLES* (<i>Rubeola</i>) one dose on or after 12 months of age, the 2nd after 15 months of age. (2MMR doses meet this requirement.) 1 RUBELLA** (<i>German Measles</i>) dose. 1 MUMPS**</p>	
<p>III. STUDENTS BORN PRIOR TO 1957 AND 49 YEAR OF AGE OR YOUNGER</p> <p>3 DTP (<i>Diphtheria-Tetanus-Pertussis</i>) or Td (<i>Tetanus-Diphtheria</i>) doses. 1 Td (<i>Tetanus-Diphtheria</i>) dose must be within the last 10 years. (If a Td booster is the only dose you document, it must be clearly marked as a booster.) 1 RUBELLA** (<i>German Measles</i>) dose.</p>	<p>IV. STUDENTS 50 YEARS OF AGE AND OLDER</p> <p>3 DTP (<i>Diphtheria-Tetanus-Pertussis</i>) or Td (<i>Tetanus-Diphtheria</i>) doses. 1 Td (<i>Tetanus-Diphtheria</i>) dose must be within the last 10 years. (If a Td booster is the only dose you document, it must be clearly marked as a booster.)</p>	
<p>Additionally, all Greensboro College 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 if test is positive).</p>		

* Rubeola (measles) vaccine must be repeated if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but physician must provide a signed statement.

** 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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SECTION C:	These vaccines are OPTIONAL .
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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.		
Last Name		First Name	Middle Name	Date of Birth (mo/day/year)
				Social Security Number

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.

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 NOT Accepted	***Titer Date & Result
** Mumps				**Disease Date NOT Accepted	***Titer Date & Result
** Rubella				**Disease Date NOT Accepted	***Titer Date & Result
Tuberculin (PPD) Test (within 12 months)	Date Read mm induration				
Chest x-ray, if positive PPD	Date Results				
Treatment, if applicable	Date				

SECTION B: RECOMMENDED IMMUNIZATIONS	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
Hepatitis B Series				***Titer Date & Result
Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	***Titer Date & Result
Meningococcal				

*** Attach lab report.

SECTION C: OPTIONAL IMMUNIZATIONS	Mo/day/year	Mo/day/year	Mo/day/year
Haemophilus influenzae type b			
Pneumococcal			
Hepatitis A Series			
Typhoid (specify type)			
Other			

* Rubeola (measles) vaccine must be repeated if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but physician must provide a signed statement.

** 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.

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

**Please return this form to: Greensboro College
815 West Market Street
Pride Box 2003
Greensboro, NC 27401-1875**

REPORT OF MEDICAL HISTORY

(Please print in black ink.)

To be completed by student

LAST NAME (print)	FIRST NAME	MIDDLE NAME	*SOCIAL SECURITY NUMBER
PERMANENT ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH	GENDER	MARITAL STATUS	
ARE YOU AN ATHLETE? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what sport?		
CLASS YOU ARE ENTERING (circle):	PREVIOUSLY ENROLLED HERE	SEMESTER ENTERING (circle)	
FR. SO. JR. SR. GRAD PROF.	IF YES, DATES?	SUMMER 1	SUMMER 2
		FALL	SPRING
		OTHER YEAR 20	

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY)		AREA CODE/TELEPHONE NUMBER
NAME OF POLICY HOLDER	*SOCIAL SECURITY NUMBER	EMPLOYER
IS THIS AN HMO/PPO/MANAGED CARE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		
POLICY OR CERTIFICATE NUMBER	GROUP NUMBER	

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 (specify)			
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				Protein or blood in urine			
Rheumatic fever				Allergy injection therapy				Rectal disease				Gall bladder trouble or gall stones			
Heart trouble/murmur				Arthritis				Severe or recurrent abdominal pain				Kidney Infection			
Pain or pressure in chest				Concussion/Loss of consciousness				Hernia				Severe menstrual cramps			
Shortness of breath				Frequent or severe headache				Easy fatigability				Irregular periods			
Asthma				Dizziness or fainting spells				Anemia or sickle cell anemia				Sexually transmitted diseases			
Pneumonia				Severe head injury				Eye trouble besides need glasses				Blood transfusion			
Chronic cough				Paralysis				Bone, joint or other deformity				Alcohol use			
Head or neck radiation treatments				Disabling depression				Knee problems				Drug use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				Anorexia/Bulimia			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Severe viral infection			
Thyroid trouble				Intestinal trouble				Back injury				Smoke 1+ pack cigarettes/week			
Diabetes				Pilonidal Cyst				Broken bone (specify)				Regularly exercise			
Serious skin disease				Frequent vomiting				Bladder infection				Seizure disorder			
Mononucleosis				Hearing loss				Kidney Stone				Other (specify)			

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FAMILY AND PERSONAL HEALTH HISTORY - CONTINUED (Please print in black ink.) To be completed by student.

Please list any drugs, medicines, birth control pills, vitamins, minerals, and/or any other supplements (prescription and nonprescription) you use and how often you use them:

Name _____ Use _____ Name _____ Use _____ Name _____ Use _____
 Name _____ Use _____ Name _____ Use _____ Name _____ Use _____
 Name _____ Use _____ Name _____ Use _____ Name _____ Use _____
 Name _____ Use _____ Name _____ Use _____ Name _____ Use _____

Check each item "Yes" or "No". Every item checked "Yes" must be fully explained in the space below (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		Yes	No
Penicillin			Do you have any conditions or disabilities that limit your physical activities in any way, including physical education and/or athletics? (If yes, please describe)		
Sulfa			Have you ever been a patient in any type of hospital? (Specify when, where, why)		
Other antibiotics (name)			Has your academic career been interrupted due to physical or emotional problems? (Please explain)		
Aspirin			Is there loss or seriously impaired function of any paired organs?		
Codeine Other Pain Relievers			Other than for a routine checkup, have you seen a physician or health-care professional in the past six months? (Please describe)		
Other drugs, medicines, chemicals (specify)			Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)		
Insect bites					
Food allergies (name)					

If you answered yes to any of the above questions, please explain here _____

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's/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 (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 Services refers out for some services and those may be billed directly to my primary insurance. I accept personal responsibility for settling the account payment of incurred charges. I am responsible for filing out patient charges with insurance.

Signature of Student

Date

Signature of Parent/Guardian, if student under age 18

Date

Please mail to:
Greensboro College
815 West Market Street
Pride Box 2003
Greensboro, NC 27401-1875