

Name _____

Semester Entering _____

Student Health Services

P.O. Box 5000, Wilson, NC 27893-7000 • (252) 399-6493

Email: studenthealth@barton.edu

Congratulations on your acceptance to Barton College! Information you provide on this health form is confidential and will be used only by the Lee Student Health Center staff to provide healthcare to you while you are a student. Please read through the form carefully, taking time to complete all required sections before returning it to Student Health Services.

**ALL NEW, TRANSFER, AND
READMITTED STUDENTS
MUST COMPLETE THIS FORM.**

FORM DEADLINES:

Fall Semester • June 15
January Term • December 15
Spring Semester • January 1
Summer Semester • May 15

North Carolina State Law (General Statute 130A - 155.1) requires that all students entering college present a certificate of immunization which documents that the student has received immunizations required by law.

The student will be administratively withdrawn from school 30 days from the date of matriculation if the immunization documentation and medical history forms have not been completed.

- You will not be able to register for classes until this form has been completed and received by Student Health Services.
- Please obtain all needed immunizations before submitting the form.
- Keep a copy of all immunization records for your personal file.
- You will be contacted after the form deadline if any portion of your record is missing or additional information is required.

Barton College Student Health Services is staffed by a Registered Nurse with supervision and referral services provided by a local physician, physician assistant, and family nurse practitioner. Student Health Services is open Monday through Friday, 10:00 a.m. until 4:00 p.m., when the College is in session. Every effort is made to provide services on campus; however, referrals to an outside facility are sometimes necessary.

Welcome to Barton! Feel free to contact us should you have any questions or concerns.

Guidelines for Completing Immunization Record

IMPORTANT

- **If you are enrolled in day classes (Monday-Friday) for five hours or more, you are subject to the immunization requirements.**
- **The Immunization Record form must be completed by a physician. Please mail the original form. Copies and facsimile transmissions will be not be accepted.**
- Records must be documented in **BLACK INK** and all corrections must be signed.
- All dates must include **month, day and year** of administration.
- Your immunization records may be obtained from your high school, physician, health department, military record, or previously attended college. These records may not fulfill all requirements. It is your responsibility to assure compliance with required immunizations. **Keep a copy for your records.**
- **Records must include a physician's signature and/or health department stamp.**
- Medical exemptions require a certified physician statement including the basis of the exemption, specific vaccine(s) the individual should not receive, and the length of time the exemption will apply.

inspiring futures

Barton College

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Section A

These Immunizations are **REQUIRED** pursuant to NC state law and institutional policy.

Students 17 years of age or younger REQUIRED:

- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one Tdap booster must have been within the **past 5 years**.
- 3 Polio (oral) doses.
- 2 Measles (Rubeola), 2 Mumps, 1 Rubella (2 MMR doses meet this requirement).

Students born in 1957 or later and 18 years of age or older REQUIRED:

- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one Tdap booster must have been within the **past 5 years**.
- 2 Measles (Rubeola), 2 Mumps, 1 Rubella (2 MMR doses meet this requirement).

Students born before 1957..... REQUIRED:

- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one Tdap booster must have been within the **past 5 years**.
- 1 Rubella dose (MMR meet this requirement) (not required if student is 50 years of age or older).

NOTE...

- History of Measles (Rubeola) is acceptable if physician verifies that student had the disease prior to January 1, 1994.
- Blood titer tests are acceptable for Measles (Rubeola), Mumps, Rubella, Hepatitis B and Varicella.
Laboratory test results must be attached.

Section B

These immunizations are **RECOMMENDED** for all students and **ARE REQUIRED FOR THE SCHOOL OF NURSING, ATHLETIC TRAINING MAJORS, and INTERNATIONAL STUDENTS** where indicated.

Section C

These vaccines are **RECOMMENDED** for all students.

Meningococcal Disease

What is Meningococcal Disease?

Meningococcal meningitis (bacterial meningitis) is a bacterial infection that causes inflammation of the membranes surrounding the brain and spinal cord. The infection is spread by direct contact with infected individuals (kissing, sharing food or drinks) or through the air via droplets or respiratory secretions (coughing or sneezing). Symptoms of this disease are similar to influenza: fever, headache, stiff neck, nausea, vomiting, and fatigue. Meningococcal meningitis can cause hearing loss, brain damage, blindness, loss of limbs, and death.

Who is at risk?

Meningococcal disease infects 3,000 Americans each year, killing approximately 300 of these individuals. The highest rates of meningococcal meningitis are seen in young children between the ages of 6 and 36 months, and in young adults on college campuses. It is estimated that 100 to 125 cases are reported each year on college campuses, resulting in 5 to 15 deaths per year.

How can you prevent Meningococcal Meningitis?

Other than basic hygiene and good personal care, there is a vaccine available for meningococcal meningitis. The menactra vaccine is safe and protects against 4 of the 5 strains of meningococcal meningitis and provides lifetime efficacy. Side effects of the vaccine are typically mild, such as redness or pain at the injection site, but like any medicine, it is capable of causing a severe allergic reaction.

Where can I get the vaccine?

Barton College students can receive the vaccine at the Lee Student Health Center when they arrive on campus. There is a small fee for the vaccination. Your local county health department or physician should also have the vaccine available.

NORTH CAROLINA STATE LAW (GENERAL STATUTE 130A - 155.1) REQUIRES THAT ALL STUDENTS ENTERING COLLEGE MUST PRESENT A CERTIFICATE OF IMMUNIZATION ON, OR BEFORE, THE FIRST DAY OF MATRICULATION INDICATING THAT THE PERSON HAS RECEIVED THE IMMUNIZATIONS REQUIRED BY LAW. Persons not in compliance with the immunization requirements 30 calendar days from the first day of matriculation will be administratively withdrawn from school by the College Registrar.

IMMUNIZATION RECORD (Please print in black ink.) To be completed and **signed** by physician or clinic.

Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	*Social Security Number
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A. REQUIRED IMMUNIZATIONS

* Required for ALL students	mo./day/year	mo./day/year	mo./day/year	mo./day/year
• DTP or TD	(#1)	(#2)	(#3)	(#4)
• Tdap Booster* within 5 years				
• 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

B. REQUIRED IMMUNIZATIONS FOR INTERNATIONAL STUDENTS, NURSING & ATHLETIC TRAINING MAJORS

* The following immunizations are recommended for all students but **are required for nursing majors, athletic training majors and international students where indicated.**

	mo./day/year	mo./day/year	mo./day/year	**Titer Date & Result
• Hepatitis B series * Required for nursing majors * Required for athletic training majors				**Titer Date & Result
• Varicella (chicken pox) series of two doses immunity by positive blood titer. * Titer result required for nursing majors			Disease Date	**Titer Date & Result
• Rubella * Titer result required for nursing majors			(Disease Date NOT Accepted)	
• Tuberculin (PPD) Test within 12 months * Result required for nursing majors, athletic training majors, and international students	Date Read	Date Read	Date Read	Date Read
	mm induration	mm induration	mm induration	mm induration
Chest x-ray, if positive PPD	Date			
	Results			
Treatment, if applicable	Date			

C. RECOMMENDED IMMUNIZATION

* Recommended for ALL students	mo./day/year	mo./day/year	mo./day/year
• Meningococcal*			
• Haemophilus influenzae type b			
• Pneumococcal			
• Hepatitis A series			
• Typhoid (specify type)			
• Other			

Signature or Clinic Stamp REQUIRED.

Signature of Physician/Physician Assistant/Nurse Practitioner _____ Date _____
 Name of Practice and Name of Physician/
 Physician Assistant/Nurse Practitioner _____ Area Code/Phone Number _____
 Office Address _____ City _____ State _____ Zip Code _____

Physician must transcribe month, date, and year of all immunizations to this form.

Barton College Student Health Services

FAMILY AND 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 fully explain the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

	Yes	No	Type of Allergic Reaction (example - hives, vomiting, confusion)
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Have you ever been a patient in any type of hospital? (Specify when, where, 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 explain.)			
Other than for a routine checkup, 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.)			

ACKNOWLEDGEMENT OF MENINGOCOCCAL VACCINE INFORMATION

North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Included in this form is information regarding bacterial meningitis and the meningococcal vaccine that follow recommendations from the Center for Disease Control of the U.S. Public Health Service.

By signing below, I am acknowledging that I received and read the information about bacterial meningitis and the meningococcal vaccine that is included on page 2 of this Student Health Services form and I am verifying whether or not I have received the meningococcal vaccine.

- I have received the meningococcal vaccine and have indicated the date on my Student Health Services form.
- I have not received the meningococcal vaccine.

Signature of Student

Signature of Parent/Guardian, if student under age 18

Date

IMPORTANT INFORMATION.....PLEASE READ AND COMPLETE

STATEMENT BY STUDENT AND PARENT/GUARDIAN:

(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 by Court order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student Health Service to release information from my (son/daughter's) medical record to physician, hospital, or other medical agency 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 staff of the Student Health Service.

Signature of Student

Date

Signature of Parent/Guardian, if student under age 18

Date

PHYSICAL EXAMINATION

(Please print in black ink.)

To be completed and **signed** by physician or clinic.**Required** for all students enrolled in day classes (Mon-Fri) and taking four or more hours. **Physical must have been in the last 12 months.**

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 _____ / _____

Vision: Right 20/ _____ Left 20/ _____ Contacts: _____ Glasses: _____ Color Vision _____ (Required for Nursing students)	Hearing: (gross) Right _____ Left _____
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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. Any restrictions to participate in any physical activity (physical education, intramurals, etc.)? Yes _____ No _____
 Explain _____

 D. Is student physically and emotionally healthy? Yes _____ No _____
 Explain _____

Signature of Physician/Physician Assistant/Nurse Practitioner _____ Date _____

 Name of Practice and Name of Physician/
 Physician Assistant/Nurse Practitioner _____ Area Code/Phone Number _____

Office Address _____ City _____ State _____ Zip Code _____

FOR STUDENTS APPLYING TO THE SCHOOL OF NURSING OR ATHLETIC TRAINING MAJORS ONLY
 Based on my assessment of this student's physical and emotional health on _____, he/she appears able to
 (Date)

 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 _____

 Name of Practice and Name of Physician/
 Physician Assistant/Nurse Practitioner _____ Area Code/Phone Number _____

Office Address _____ City _____ State _____ Zip Code _____

MUST BE COMPLETED WITHIN 6 MONTHS OF APPLICATION DEADLINE

*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.