# Student Health Services

**P.O. Box 5605, Wilson, NC 27893-7000 • (252) 399-6493**
**Email: healthcenter@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 PRIOR TO AUGUST 1.

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## Barton College Immunization Policy

North Carolina state law, N.C.G.S.§130A-155.1 mandates students attending a college or university, whether public or private, to present a Certificate of Immunization or a record of an immunization from a high school. In general, the law requires those students who reside on campus or students residing off-campus who are taking five (5) or more traditional day credit hours on campus per semester, must meet the North Carolina State Law Immunization requirements contained in the student health form. Exceptions to this law include: students who have a bona fide documented medical or religious exemption; students who reside off-campus and are exclusively enrolled in only weekend, evening, online courses; and students enrolled in no more than four (4) traditional day hours per semester.

Immunizations for enrollment should be obtained prior to attending Barton College at a local physician's office, health department, medical office or urgent care provider. The Lee Student Health Center provides the medical form for each deposited students and any student failing to submit this form and immunization documents or who fails to meet any immunization exception will be administratively withdrawn from registered courses. Failing to provide a completed student health form, immunization results, and health history information, will result in administrative dismissal from the College. If students do not meet the immunization requirements, dismissal from Barton College is mandatory under North Carolina Law.

## Guidelines for Completing Immunization Record

### IMPORTANT

- Records must be documented in **BLACK INK** and all corrections must be signed.
- All immunization 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.**

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Revised Spring 2016

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

*Students born after June 30, 1994*

**REQUIRED:**

- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one Tdap booster must have been within the **past 10 years.**
- 3 Polio (oral) doses. (An individual who has attained his or her 18th birthday is not required to receive polio vaccine)
- 2 Measles (Rubeola), 2 Mumps, 1 Rubella (2 MMR doses meet this requirement).
- 3 Hepatitis B vaccines.

*Students born in 1957 through June 30, 1994*

**REQUIRED:**

- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one Tdap booster must have been within the **past 10 years.**
- 2 Measles (Rubeola), 2 Mumps, 1 Rubella (2 MMR doses meet this requirement).
- 3 Polio (oral) doses. (An individual who has attained his or her 18th birthday is not required to receive polio vaccine)

*Students born before 1957*

**REQUIRED:**

- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one Tdap booster must have been within the **past 10 years.**

**NOTE:** *Blood titer tests are acceptable for Measles (Rubeola), Mumps, Rubella, and Varicella.*

**Laboratory test results must be attached.**

**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 |
|---|---|---|---|---|
| | | | | |

REQUIRED FOR **ALL** STUDENTS

| **A. REQUIRED IMMUNIZATIONS** | mo./day/year | mo./day/year | mo./day/year |
|---|---|---|---|
| • DTP or TD | (#1) | (#2) | (#3) |
| • Tdap Booster **within 10 years** | (#1) | (#2) | (#3) |
| • Polio (If under 18 years of age) | (#1) | (#2) | (#3) |
| • MMR | (#1) | (#2) | (#3) |
| • Hepatitis B series | (#1) | (#2) | (#3) |
| • Tuberculin (PPD) Test **within 12 months** of application date<br>* Result required for international students<br>* Chest x-ray result required if history of positive PPD or BCG vaccination<br>Treatment, if applicable | Date Read | Date Read | Date Read |
| | mm induration | mm induration | mm induration |
| | Date | | |
| | Results | | |
| | Date | | |

## Section B These immunizations are **RECOMMENDED** for all students.

| **B. RECOMMENDED IMMUNIZATIONS** | mo./day/year | mo./day/year | mo./day/year |
|---|---|---|---|
| • Meningococcal | | | |
| • Varicella | | | |
| • Haemophilus influenzae type b | | | |
| • Pneumococcal | | | |
| • Hepatitis A series | | | |
| • Typhoid (specify type) | | | |
| • HPV | | | |
| • 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** _____

**Physician or Health Department must transcribe month, date, and year of all immunizations to this form.**

# Barton College Student Health Services

## 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 AREA CODE/PHONE

EMAIL ADDRESS _____

DATE OF BIRTH (mo/day/yr) _____ GENDER ☐ M ☐ F

PREVIOUSLY ENROLLED HERE ☐ YES ☐ NO SEMESTER ENTERING (circle): FALL SPRING YEAR 20 _____

Health Insurance
(name and address of company) _____ Area Code / Phone ( ____ ) _____ - _____

Name of Policy Holder _____ Policy Holder Date of Birth _____

Policy Holder Employer _____ Policy / Certificate # _____ Group # _____

Emergency Contact Name _____ Relationship _____ Phone # _____

Address _____ City _____ State _____ Zip _____

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 permission. *Please attach additional sheets for any items that require more explanation. See next page.*

## 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 | | | |
| Tuberculosis | | | |
| 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 headaches | | | |
| Dizziness or fainting spells | | | |
| Severe head injury | | | |
| Paralysis | | | |
| Epilepsy/Seizures | | | |
| 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 | | | |
| Shoulder dislocation | | | |
| Knee problems | | | |
| Recurrent back pain | | | |
| Neck injury | | | |
| Back injury | | | |
| Broken bone (specify) | | | |
| Kidney infection | | | |
| Bladder infection | | | |

| | Yes | No | Year |
|---|---|---|---|
| Kidney stone | | | |
| Protein or blood in urine | | | |
| Hearing loss | | | |
| Sinusitis | | | |
| Severe menstrual cramps | | | |
| Irregular periods | | | |
| Sexually transmitted disease | | | |
| Blood transfusion | | | |
| Smoke 1 + pack cigarettes/week | | | |
| Alcohol use | | | |
| Drug use | | | |
| Anorexia/Bulimia | | | |
| Other (specify) | | | |
| | | | |
| | | | |
| | | | |

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name_____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name_____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name_____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

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).

| | 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.) | | | |

Please list any known DRUG allergies and reactions: _____

_____

_____

Please list any known FOOD allergies and reactions: _____

_____

_____

## IMPORTANT INFORMATION ... READ AND SIGN

# Meningococcal Disease

Meningococcal disease refers to any illness that is caused by the type of bacteria called Neisseria meningitidis, also known as meningococcus. These illnesses are often severe and include infections of the lining of the brain and spinal cord (meningitis) and bloodstream infections (bacteremia or septicemia). Meningococcus bacteria are spread through the exchange of respiratory and throat secretions like spit (e.g., by living in close quarters, kissing, sharing food and drink). Meningococcal disease can be treated with antibiotics, but quick medical attention is extremely important

The symptoms include sudden onset of fever, headache, and stiff neck. There are often additional symptoms, such as nausea, vomiting, photophobia (increased sensitivity to light), and altered mental status (confusion).
The symptoms of meningococcal meningitis can appear quickly or over several days. Typically they develop within 3-7 days after exposure.

Infectious diseases tend to spread quickly wherever large groups of people gather together. As a result, first-year college students living in residence halls are at slightly increased risk compared with other persons of the same age. A meningococcal vaccine is available and recommended for all first-year college students living in a residence hall. However, any college student can receive the vaccine to decrease their chances of getting meningococcal disease

Keeping up to date with all recommended immunizations is the best defense against meningococcal disease and other infectious diseases. Maintaining healthy habits, like getting plenty of rest and not coming into close contact with people who are sick, can also help.

The meningococcal vaccine may be obtained at the Lee Student Health Center when students arrive on campus. There is a fee for vaccination. Meningococcal and other recommended immunizations may also be received at your local health department or physician’s office prior to your arrival on campus.

**STATEMENT BY STUDENT AND PARENT/GUARDIAN (If student is under age of 18):**

1) 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 medical record to physician, hospital, or other medical agency involved in providing me with emergency treatment and/or medical care.

2) I hereby authorize any medical treatment for myself that may be advised or recommended by the staff providers of the Student Health Services.

3) I have read the above information about menigococcal disease and the availability of the meningoccal vaccine.

_____ _____
Signature of Student Date

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