Health Information & Immunization Form

Wake Forest University Student Health Service
P.O. Box 7386 | 1834 Wake Forest Road | Reynolds Gymnasium
Winston-Salem, NC 27109
Phone 336-758-5218 | Fax: 336-758-6054
shs.wfu.edu

PLEASE MAIL ATTACHED PAGES 1-4 TO ABOVE ADDRESS

Acceptable Records of your Immunizations may be obtained from any of the following:

- **Personal Shot Records**—Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- **High School Records**—These may contain some, but not all, of your immunization information. Your immunization records do not transfer automatically. You must request a copy.
- **Local Health Department.**
- **Previous College or University Records**—Your immunization records do not transfer automatically. You must request a copy.
- **Military Records or WHO (World Health Organization) Documents**—These records may not contain all of the required immunizations.

COUNTRIES WITH ESTIMATED OR REPORTED TUBERCULOSIS INCIDENCE, 2010

(Source: World Health Organization and American College Health Association Guidelines)

"Low Incidence" areas are defined as areas with reported or estimated incidence of <20 cases per 100,000 population
Albania, Andorra, Antigua and Barbuda, Australia, Austria, Bahamas, Barbados, Belgium, British Virgin Islands, Canada, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, French Polynesia Germany, Greece, Grenada, Hungary, Iceland, Iran (Islamic Republic of), Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mexico, Montenegra, Nauru, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Samoa, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tonga, Trinidad and Tobago, United Arab Emirates, United Kingdom, United States of America, West Bank and Gaza Strip

Information about Meningococcal Disease and Meningococcal Vaccine

NC House Bill 825 requires that all private and public institutions with on-campus residents to provide information about meningococcal disease. Below you will find information regarding meningococcal disease, including recommendations from the Centers for Disease Control (CDC).

Meningococcal disease continues to pose a small but definite risk to college students. Freshmen, particularly those that live in residence halls, constitute a group at modestly increased risk of meningococcal disease relative to other persons their age.

The disease is caused by the bacteria Neisseria meningitides. These bacteria can live unnoticed in individuals ("carrier state") with no symptoms. Occasionally, the bacteria will invade the bloodstream and cause meningitis, pneumonia, or pharyngitis (sore throat). Individuals who have close contact with a "carrier" or with an individual who has one of these illnesses may become infected with the bacteria also. The disease tends to occur in late winter and early spring, overlapping with the flu season. Even if promptly treated, meningococcal disease may progress rapidly and cause serious medical problems including death.

It is recommended that all college freshmen living in residence halls be vaccinated against meningococcal disease. The CDC recommends the first vaccine be given at age 11 or 12 years, with a booster dose at age 16 years. Persons who receive their first vaccine on or after their 16th birthday do not need a booster dose.

All in-coming Wake Forest students who desire the vaccine should get it from their family physician or local health department. Other students wishing to reduce their risk of meningococcal disease can also choose to be vaccinated. The WFU Student Health Service has the vaccine available, and it is available at the Forsyth County Health Department.

For more information Meningococcal Disease, go to the CDC at: ***http://www.cdc.gov/meningitis/index.html.***

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2013-2014 Health Information & Immunization Form

Confidentiality: Student medical records are confidential. Medical records and information contained in the records may be shared with therapists and physicians who are involved in the student's care, and otherwise will not be released without the student's permission except as allowed by law. Students who wish to have their medical records or information released to other parties should complete a release of information form at the time of each office visit or service.

Authorization and Consent: All students must sign the authorization and consent below. If the student is under the age of 18, a parent or guardian must also sign.

Deadline: Fall enrollment-July 1, Spring enrollment-January 1, or Summer school only-May 1.

To be completed by Student **If completing by hand, please use black ink.**

Last Name	First Name	Middle Name	Date of Birth	WFU ID#

Permanent Address _____
Street City State Zip Code

Cell Phone _____ Email Address _____
area code

Gender: ☐ Male ☐ Female ☐ Transgender _____Age Marital Status: ☐ Single ☐ Married ☐ Domestic Partner

USA Citizen? ☐ Yes ☐ No If no, what is your nationality: _____

Class you are Entering: ☐ Fr. ☐ So. ☐ Jr. ☐ Sr.
☐ Graduate School of Arts & Sciences ☐ School of Law
☐ Graduate Schools of Business ☐ School of Divinity
Semester Entering: ☐ Fall ☐ Spring ☐ Summer school only Year _____
Previously Enrolled at WFU? ☐ Yes ☐ No

In case of Emergency, contact: _____ Relationship _____

Cell Phone _____ Home Phone _____ Bus. Phone _____
area code area code area code

Address _____
Street City State Zip Code

Email Address _____

Health Insurance Information Required or Submit Copy of Both Sides of Insurance ID Card
You must visit http://sip.studentlife.wfu.edu/ to complete the health insurance enrollment/waiver form, in addition to completing this section.

Insurance Company. _____ Subscriber's ID No. _____ Group No. _____

Subscriber's Name: _____ Ins. Co. Phone Number: _____

Address of Ins. Co. _____

Important Information—Please read and complete:

Authorization and Consent: I hereby agree that the attending physician or whomever he or she may designate may undertake treatment, including operations and/or the administration of necessary anesthesia, in serious or major illnesses or injuries without prior notification of the undersigned or any other person and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending physician or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. In the case of a minor student, (under the age of 18) this treatment may proceed without prior notification of the undersigned parent or guardian. I also agree that needed immunizations may be administered. I further agree that the Student Health Service may release any medical information to other health care providers who are involved in my care.

Sign this form after printing
_____ Date _____ / _____ / _____
Signature of Student

If you are under 18, have your parent or guardian sign this form after printing
_____ Date _____ / _____ / _____
Signature of Parent/Guardian, if student under age 18

Last Name	First Name	Middle Name	Date of Birth	WFU ID#

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Family Medical History

Have any of your relatives ever had any of the following?

	Yes	Relationship
Alcohol or drug abuse	☐	
Asthma	☐	
Cancer (type)	☐	
Diabetes	☐	
Heart disease	☐	
Hereditary disease	☐	
High blood pressure	☐	
Migraine headaches	☐	
Nervous or mental disease	☐	
Are you adopted?	☐	

PERSONAL HISTORY

Comment on all positive answers below.

Are you allergic to:	Yes
Penicillin	☐
Sulfonamides	☐
Peanuts	☐
Bees, wasps	☐
Other medications/foods	☐
Specify:	
Do you receive allergy injections?	☐

Have you had:	Yes
Mononucleosis	☐
Chickenpox	☐
Hepatitis B	☐
Hepatitis C	☐
HIV	☐
Tropical disease	☐
Specify:	
Hearing disabilities	☐
Vision problems	☐
Corrective lenses	☐
Asthma	☐
Respiratory disorder	☐
Heart disease	☐
High blood pressure	☐
Stomach or intestinal disorders	☐
Menstrual cycle disorders	☐
Kidney disease	☐
Sexually transmitted diseases	☐
Anemia	☐
Blood disorders	☐
Diabetes	☐
Thyroid disease	☐
Other endocrine disorders	☐

Have you had:	Yes
Headaches	☐
Migraines	☐
Neurological disorder	☐
Seizures	☐
Alcohol abuse problems	☐
Other drug use problems	☐
Smoking/tobacco use	☐
Eating disorder	☐
Depression	☐
Anxiety	☐
ADD, ADHD	☐
Diagnosed learning disorder	☐
Other psychological disorder	☐
Cancer	☐
Chronic medical condition	☐
Specify:	
Surgery or serious injury	☐
Serious head injury	☐
Concussion	☐
Mobility disorder	☐
Organ loss	☐
Victim of personal assault, rape	☐

Current prescription medicines – list

Current non-prescription medicines – list

Current vitamins or supplements – list

	Yes
A. Have you received treatment or counseling for a psychiatric or psychological problem (e.g. depression, eating disorders, anxiety)? *Please document below.*	☐
B. Have you had any illness or injury or been hospitalized other than already noted? *Please document below.*	☐
C. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years, except for routine exams or minor illnesses or injuries? *Please document below.*	☐

Please give details for any positive answers above. _____

Will you be participating on a WFU NCAA athletic team? ☐ Yes ☐ No Which sport? _____

Date: _____

PRINT

Last Name	First Name	Middle Name	Date of Birth	WFU ID#

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete this form. Please comment on all positive answers. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect his/her status; it will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Service and will not be released without student consent. Thank you for your cooperation in completing this form. Please complete the **IMMUNIZATION RECORD ON PAGE 4, required by North Carolina Law.**

PHYSICAL FINDINGS

Height		cm/in
Weight		kg/lb
Pulse		bpm
Blood pressure	—systolic	mmHg
	—diastolic	mmHg
Hemoglobin		g/dl
Hematocrit		%
Urinalysis:	protein	units
	sugar	units
	wbc's	units
	rbc's	units

VISUAL ACUITY

Left eye:	
corrected	
uncorrected	
Right eye:	
corrected	
uncorrected	

PRINT FOR PHYSICIAN TO COMPLETE

TAPE PHOTO HERE

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS?

		No	Yes	Describe fully
Physical Findings	Head, ears, nose or throat			
	Respiratory			
	Cardiovascular			
	Gastrointestinal			
	Hernia			
	Eyes			
	Genitourinary			
	Metabolic/Endocrine			
	Neuropsychiatric			
	Skin			
	Organ loss or impairment			
	Musculoskeletal			
Regular medicines - list names and dosages				
Disabilities - list				

SICKLE CELL SCREEN (IF APPLICABLE): DATE _____ RESULTS _____

Recommendations for physical activity (PE, Intramurals, ROTC) ☐ Unlimited ☐ Limited (*Explain below*)

Do you have any recommendations regarding the care of this student? ☐ No ☐ Yes (*Explain below*)

Is the patient now under treatment for any medical or emotional condition? ☐ No ☐ Yes (*Explain below*)

Have you any general comments? ☐ No ☐ Yes _____

_____

If this student has a disability or condition that requires special housing considerations, please forward that information to:

Student Health Service, PO Box 7386, Winston-Salem, NC 27109.

If this student has a disability or condition that requires an academic accommodation, please forward that information to:

Learning Assistance Center, PO Box 7283, Winston-Salem, NC 27109.

Specific information about both of the above may be found at: *lac.wfu.edu/files/2011/07/PhysPsy-Guidelines.pdf*

PLEASE NOTIFY US OF ANY MEDICAL PROBLEMS THAT DEVELOP AFTER THIS EXAMINATION.

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner Date

_____

Print name of Physician/Physician Assistant/Nurse Practitioner

_____ _____

Office Address Area Code/Phone Number

Are you the student's primary care physician? ☐ Yes ☐ No If "no," how long have you known student? _____

PRINT

Last Name	First Name	Middle Name	Date of Birth	WFU ID#

In order to attend Wake Forest University, you must comply with North Carolina Immunization requirements, even though your state or country of origin may have different requirements.

1. Have this form completed and **signed by your healthcare provider.**
2. Mail, fax or email this completed form to Wake Forest University Student Health Service: PO Box 7386, Winston Salem, NC 27109; Fax: 336-758-6054; Email: shs@wfu.edu

DATE FORMAT: MM/DD/YYYY

Diphtheria/Pertussis/Tetanus: Minimum of 3 doses to include a **Tdap** documented since **June 2005.**

#1_____/_____/_____, #2 _____/_____/_____, #3 _____/_____/_____, #4 _____/_____/_____, #5 _____/_____/_____

Booster Td _____/_____/_____ **Tdap** _____/_____/_____

MMR: 2 doses are required. If given as single antigen dose, must have 2 Measles, 2 Mumps and 1 Rubella.

MMR Dose 1 at age 12-15 months or later _____/_____/_____

MMR Dose 2 at age 4-6 years or later, and at least one month after first dose _____/_____/_____

Measles ____/____/____ **Measles** ____/____/____ **Mumps** ___/____/____ **Mumps** ____/____/____ **Rubella** ____/____/_ __

(A positive Measles, Mumps, Rubella antibody titer meets the requirement. **Lab report must be attached.**)

Polio (3 doses required for students under 18 years of age) ☐ IPV ☐ OPV

#1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____ #4_____/_____/_____

Hepatitis B Series: 3 doses are required if born on or after July 1, 1994

Minimum 28 days between doses 1 and 2
Minimum 28 days between doses 2 and 3
Minimum 6 months between doses 1 and 3

#1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____

Test for TB is required within12 months of university registration date IF:

(a) The student has been exposed to tuberculosis or has signs or symptoms of active tuberculosis disease **OR**
(b) The student has resided more than 30 days in a country other than those listed as "Low incidence" on page A

Tuberculin Skin Test: Date administered:_____/_____/_____ Date read:_____/_____/_____ Result:_____mm

OR

Tuberculin Blood Test: Date:_____/_____/_____ Result:_____

If TB test is positive: Chest x-ray is required if tuberculin skin test is positive Date done:_____/_____/_____ ☐ Normal ☐ Abnormal

Meningococcal: Recommended for undergraduates. (If initial dose is given before 16 years of age, booster is necessary.)

#1 _____/_____/_____ #2 _____/_____/_____

Recommended vaccines, but not required:

Hepatitis A #1_____/_____/_____ #2_____/_____/_____ **Pneumovax:** _____/_____/_____

Varicella #1_____/_____/_____ #2_____/_____/_____ History of Disease _____/_____/_____

Gardasil OR Cervarix (HPV) #1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____

Not required:

Yellow Fever:_____/_____/_____ Typhoid IM _____/_____/_____ Typhoid oral _____/_____/_____

Signature of Healthcare Provider:

Name (print)_____Address/Clinic Stamp_____

Signature_____Phone (_____)_____