

# Wake Forest University

## 2019-2020 Health Information & Immunization Form

North Carolina General Statute §130A 152-157 requires that **ALL** students entering college present a certificate of immunization which documents that the student has received the immunizations that are required by law. This documentation must be signed by a healthcare provider and include an office address. Students may be withdrawn from the university 30 days after classes begin if the mandatory immunization and TB requirements have not been met.

### Deadlines for submission OF ALL 5 PAGES:

Fall admission – July 1  
Spring admission – January 1  
Summer admission – May 1

#### Basic Instructions:

- All Immunization records are required to be submitted in, or translated into English, and in MM/DD/YYYY format.
- Include name and Wake ID number on all forms.
- Forms completed at a doctor's office, clinic or health department must contain an "official Stamp" and/or clinician signature for documents to be complete and accepted.
- KEEP A COPY FOR YOUR RECORDS.

#### The following steps are MANDATORY:

- **Step 1:** Have a doctor's office, clinic or health department complete the Immunization Form.
- **Step 2:** Complete the Tuberculosis Questionnaire -**All incoming students must be screened for Tuberculosis risk factors through a screening questionnaire**
- **Step 3:** Mail or email the completed Immunization Requirements Form and TB Screening Questionnaire to:

#### Wake Forest University Student Health Service

P.O. Box 7386  
Winston-Salem, NC 27109

OR

[hiif@wfu.edu](mailto:hiif@wfu.edu)

#### 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 records. 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.

**IMPORTANT!** Your information will be reviewed by staff. You will be notified via post card or email if additional information is needed. Keep a copy for your records. There are occasions when you may need to resubmit your documentation.



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

<b>FAMILY HISTORY</b>					
	Age	State of Health	Occupation	Age of Death	Cause of Death
Parent					
Parent					
Brothers					
Sisters					

<b>FAMILY MEDICAL HISTORY</b>		
Have any of your relatives ever had any of the following?		
	Yes	Relationship
Blood Clots (lung or leg)		
Asthma		
Cancer (type)		
Diabetes		
Heart disease		
Hereditary disease		
High Blood Pressure		
Migraine headaches		
Mental health condition		
Are you adopted?		

**PERSONAL HISTORY**  
*Comment on all positive answers below.*

Are you allergic to:	Yes to all that apply
Penicillin	
Sulfonamides	
Peanuts	
Bees, wasps	
Other medications/foods	
Specify:	
<b>Do you receive allergy injections?</b>	
<b>Have you had:</b>	<b>Yes to all that apply</b>
Mononucleosis	
Chickenpox	
Hepatitis B	
Hepatitis C	
HIV	
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 infections	
Anemia	
Blood disorders	
Diabetes	
Thyroid disease	
Other endocrine disorders	

Have you Had:	Yes to all that apply
Migraines or chronic headaches	
Neurological disorder	
Seizures	
Alcohol abuse problems	
Other drug use problems	
Smoking/tobacco use	
Eating disorder	
Depression	
Anxiety	
ADD,ADHD	
Diagnosed learning disorder	
Other Mental Health Conditions	
Specify:	
Cancer	
Chronic medical condition	
Specify:	
Surgery or serious injury	
Serious head injury	
Concussion	
Mobility disorder	
Organ loss	
Victim of personal or sexual assault, rape	
<b>Current prescription medicines – list</b>	
<b>Current non-prescription medicines – list</b>	

	Yes to all that apply		Yes to all that apply
A. Have you received treatment or counseling for a psychiatric or psychological problem (e.g. depression, eating disorders, anxiety)? <i>Please document below.</i>		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? <i>Please document below.</i>	
B. Have you had any illness or injury or been hospitalized other than already noted? <i>Please document below.</i>			

Please give details for any positive answers above: \_\_\_\_\_

Will you be participating on a WFU NCAA athletic team?    Yes    No    Which Sport? \_\_\_\_\_

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

Tuberculosis (TB) Screening Questionnaire: All new students are required to complete and submit the following TB screening questionnaire form (part 1)

**SECTION A: Tuberculosis (TB) Exposure Risk**

1. Please answer the following questions:

- a) Have you ever had close contact with persons known or suspected to have active TB disease?      **YES**      **NO**
- b) Have you ever lived with or been in close contact to a person known or suspected of being sick with TB?      **YES**      **NO**
- c) Have you ever lived, worked or volunteered in any homeless shelter, prison/jail or long term care facility?      **YES**      **NO**
- d) Have you ever been a member of any of the following groups that may have an increase incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, abusing alcohol or drugs?      **YES**      **NO**

2. Were you born in, or have you lived, worked or visited for > 1 month in one of the following countries listed in the boxes below?

**YES**      **NO**

**If YES, where? \_\_\_\_\_ How long? \_\_\_\_\_ Dates visited/ lived \_\_\_\_\_**

Afghanistan	Burundi	Eritrea	Kazakhstan	Micronesia (Federal States)	Guinea	Sri Lanka	Viet Nam
Algeria	Burma (Myanmar)	Ethiopia	Kenya	Moldova (Republic of)	Paraguay	Sudan	Wallis and Futuna Islands
Angola	Cabo Verde	Fiji	Kiribati	Mongolia	Peru	Suriname	Yemen
Argentina	Cambodia	French Polynesia	Kuwait	Morocco	Philippines	Swaziland	Syrian Arab Republic*
Armenia	Cameroon	Gabon	Kyrgyzstan	Korea (North and South)	Portugal	Tajikistan	Zambia
Azerbaijan	Central African Republic	Gambia	Kyrgyzstan	Lao	Qatar	Thailand	Zimbabwe
Bangladesh	Chad	Guam	Latvia	Lesotho	Romania	Timor-Leste	
Belarus	China	Guatemala	Latvia	Lithuania	Russian Federation	Togo	
Belize	Colombia	Haiti	Madagascar	Madagascar	Tanzania (United Republic)	Tunisia	
Benin	Congo (Democratic Republic)	Honduras	India	Malawi	Tanzania (United Republic)	Turkmenistan	
Bhutan	Cote d'Ivoire	Indonesia	Iran *(Islamic Republic of)	Malaysia	Sierra Leone	Tuvalu	
Bolivia	Djibouti	Madagascar	Iraq	Maldives	Singapore	Ukraine	
Bosnia and Herzegovina	Dominican Republic	Malawi	Mali	Maldives	Singapore	Ukraine	
Botswana	Ecuador	Malawi	Maldives	Maldives	Singapore	Ukraine	
Brazil	El Salvador	Malawi	Maldives	Maldives	Singapore	Ukraine	
Brunei Darussalam	Equatorial Guinea	Malawi	Maldives	Maldives	Singapore	Ukraine	
Bulgaria	Guinea	Malawi	Maldives	Maldives	Singapore	Ukraine	
Burkina Faso		Malawi	Maldives	Maldives	Singapore	Ukraine	

**If YES to any of the above questions, Wake Forest University requires TB testing within 6 months of arriving on campus. If the answer to all of the questions is NO, no further action is needed.**

**FOR HEALTHCARE PROVIDER TO COMPLETE: Tuberculosis (TB) Risk Assessment**

Clinicians should review and verify the information in Section A. Persons answering YES to any of the questions in Section A are candidates for either Mantoux tuberculin skin test (TST) Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below)      **YES**      **NO**

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: Date done: \_\_\_/\_\_\_/\_\_\_**

Normal      Abnormal (**must attach radiology report**)

Provider Name (print) \_\_\_\_\_ Address/Clinic stamp \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PRINT PAGE FOR HEALTHCARE PROVIDER TO COMPLETE**

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 or email this completed form to Wake Forest University Student Health Service: PO Box 7386, Winston Salem, NC 27109; Email: [hiif@wfu.edu](mailto:hiif@wfu.edu) **DO NOT FAX**

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

**SECTION A REQUIRED IMMUNIZATIONS**

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Students must submit documentation of 3 DTP, Td, or Tdap vaccines regardless of age. One MUST be a Tdap, one must be within the past 10 years. <b>DTaP/DTP/Td</b> (diphtheria/Tetanus/Pertussis or Tetanus/Diphtheria Toxoid)	<b>DTaP</b>			
	<b>DTP</b>			
	<b>Td</b>			
<b>Tdap booster</b> (All students MUST show proof of a Tdap booster given since 2005)				
<b>Polio</b> (3 doses required for students under 18 years of age)				
<b>MMR</b> (Measles, Mumps, Rubella - 2 MMR vaccines required on or after first birthday OR 2 Measles, 2 Mumps, and 1 Rubella single doses OR positive Measles, Mumps, Rubella titers)				
<b>Measles</b> (2 required on or after first birthday OR positive titer OR documented disease date)			Disease Date	**Titer Date & Result
<b>Mumps</b> (2 required on or after first birthday OR positive titer)			<b>Disease Date NOT Accepted</b>	**Titer Date & Result
<b>Rubella</b> (1 required on or after first birthday OR positive titer)			<b>Disease Date NOT Accepted</b>	**Titer Date & Result
<b>Hepatitis B Series</b> (only required if born on or after July 1, 1994)				<b>Titer NOT Accepted for required Hep B Series</b>
<b>Varicella</b> (Only required if born on or after April 1, 2001. Positive titer OR date of disease is acceptable)			Disease Date	**Titer Date & Result
<b>Meningococcal Quadrivalent ACYW-135</b> (Menactra, Menveo) A dose is required ≥ age 16 years for all undergraduates. Meningococcal B vaccine <b>DOES NOT</b> fulfill this requirement. Recommended for graduate/professional students through age 21				

**SECTION B RECOMMENDED IMMUNIZATIONS**

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
<b>Hepatitis A</b>				
<b>Human Papillomavirus (HPV)</b>	Cervarix			
	Gardasil			
	Gardasil-9			

**SECTION C RECOMMENDED IMMUNIZATIONS FOR CERTAIN PATIENTS / MEDICAL CONDITIONS**

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
<b>Meningococcal Group B</b>	<b>Trumenba</b>			
	<b>Bexsero</b>			
<b>Pneumovax</b>				
<b>Yellow Fever</b>				
<b>Typhoid IM</b>				
<b>Typhoid oral</b>				
<b>Other</b>				

Signature or Healthcare Provider: \_\_\_\_\_

Name (Print) \_\_\_\_\_ Address/Clinic Stamp \_\_\_\_\_

Signature \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**PRINT PAGE FOR HEALTHCARE PROVIDER TO COMPLETE**

Wake Forest University Student Health Service  
P.O. Box 7386 | Winston-Salem, NC 27109

Office: (336) 758-5218  
Email: hiif@wfu.edu

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

**REPORT OF HEALTH EVALUATION**

TO THE EXAMINING PHYSICIAN: Please review the student’s history and complete this form.  
THIS STUDENT HAS BEEN ACCEPTED. The information supplied **will not** affect his/her status; it will be used only as a back-ground 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 AND THE TUBERCULOSIS SCREENING QUESTIONNAIRE ON PAGE 3, required by Wake Forest policy or North Carolina Law.

<b>Physical Findings</b>		Was physical examination normal? ___ Yes ___ No If no, please explain abnormality:
Height	cm/in	
Weight	kg/lb	
Pulse	bpm	
Blood Pressure - systolic	mmHg	
Blood Pressure - diastolic	mmHg	
Medication allergies:		
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, meal plan considerations or academic accommodation, please forward that information to: Learning Assistance Center, PO Box 7283, Winston-Salem, NC 27109.

Specific information about the above may be found at: <http://lac.wfu.edu/files/2011/07/Guidelines-for-Physical-or-Psychiatric-2016.pdf>

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

**Medical Providers: Please complete the mandatory immunization and TB risk assessment forms on the following 2 pages**

\_\_\_\_\_  
Signature of Physician/Physician Assistant/Nurse Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Physician/Physician Assistant/Nurse Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Address

\_\_\_\_\_  
Area Code/Phone Number

Are you the student’s primary care physician? Yes No If “no,” how long have you known student? \_\_\_\_\_

## ***Guidelines For Completing The Immunization Record***

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

Be certain that your Name, Date of Birth, and Student ID Number appear on each sheet and that all forms are mailed together. The records must have the vaccine administration dates. The dates **MUST** include the month, day, and the year.

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

- Personal Shot Records / Local Health Department - Must be verified by a doctor's stamp or signature, or by a clinic or health department stamp with address.
- Military Records or WHO (World Health Organization) Documents - These records may not contain all of the required immunizations. Required records within these documents are however accepted. Must have clinic address.
- Previous College or University Records - Your immunization records do not transfer automatically. You must request to have copy sent to our immunizations department. Must have clinic address.

## ***College / University Vaccines and Number of Dose Requirements***

<b>Vaccine</b>	<b>Number of Doses Required Before School Entry*</b>
Diphtheria, tetanus and pertussis <sup>1</sup>	3 doses
Polio <sup>2</sup>	3 doses
Measles <sup>3</sup>	2 doses
Mumps <sup>4</sup>	2 doses
Rubella <sup>5</sup>	1 dose
Hepatitis B (Hep B) <sup>6</sup>	3 doses
Varicella <sup>7</sup>	2 doses
Meningococcal: Quadrivalent ACYW-135 <sup>8</sup>	1 dose on or after the 16 <sup>th</sup> birthday

Footnote 1 - Three doses are required for individuals entering college or university. Individuals entering college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid; one of which must be tetanus/diphtheria/pertussis. Given since 2005.

Footnote 2 - Three doses are required for individuals entering college or university. An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

Footnote 3 - Two doses at least 28 days apart are required for individuals entering college or university. The requirement for a second dose does not apply to individuals who entered school, college, or university for the first time before July 1, 1994. A person who has been diagnosed prior to January 1, 1994 by a physician (or designee such as a nurse practitioner or physician's assistant) as having measles (rubella) or an individual who has been documented by serological testing to have a protective antibody titer against measles is not required to receive measles vaccine. Individuals born before 1957 are not required to receive measles vaccine except in measles outbreak situations.

Footnote 4 - Two doses are required for individuals entering college or university. A physician's diagnosis is not acceptable for mumps disease(s). Individuals must be immunized or have laboratory confirmation of disease or have documented by serological testing to have a protective antibody against mumps. Individuals born before 1957 are not required to receive the mumps vaccine. Individuals that entered college or university before July 1, 1994 are not required to receive the vaccine. Individuals that entered school, college, or university before July 1, 2008 are not required to receive the second dose of mumps vaccine.

Footnote 5 - One dose is required for individuals entering college or university. A physician's diagnosis is not acceptable for rubella disease(s). Individuals must be immunized or have laboratory confirmation of rubella disease or have been documented by serological testing to have a protective antibody titer against rubella. Any individual who has attained his or her fiftieth birthday is not required to receive rubella vaccine except in outbreak situations. Any individual who entered college or university after his or her thirtieth birthday and before February 1, 1989 is not required to receive rubella vaccine except in outbreak situations.

Footnote 6 - Three doses are required for individuals entering college or university. Hepatitis B vaccine is not required if an individual was born before July 1, 1994.

Footnote 7 - Varicella is not required if an individual was born before April 1, 2001. Individuals entering Kindergarten or first grade for the first time before July 1, 2015 are not required to receive the second dose of varicella vaccine.

Footnote 8 - Meningococcal Quadrivalent ACYW-135 is required of all undergraduate students. One dose on or after the 16<sup>th</sup> birthday. Recommended for graduate and professional students.

\*Must repeat Rubeola (measles) vaccine if received more than 4 days 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.

\*\*\*Vaccine, laboratory proof of immunity, or history of disease with a signed physician statement is acceptable to varicella.

## ***Meningococcal (meningitis) Disease***

**Meningococcal Disease** is a rare but potentially fatal bacterial infection caused most often by the bacterium *Neisseria meningitidis*. Meningococcal Meningitis is an inflammation of the membranes surrounding the brain and spinal cord that can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death. Meningococcal bacteria are transmitted through the air via droplets of respiratory secretion, by oral contact with shared items, such as cigarettes or drinking glasses, by kissing, or by direct contact with an infected person. Although anyone can come in contact with the bacteria that cause meningococcal disease, data also indicate certain social behaviors, such as exposure to passive and active smoking, bar patronage, and excessive alcohol consumption, may put students at increased risk for the disease. Patients with respiratory infections, compromised immunity, those in close contact to a known case, and travelers to endemic areas of the world are also at increased risk.

**Symptoms** usually associated with meningococcal disease include fever, severe headache, stiff neck, rash, nausea, vomiting, and lethargy, and may resemble the flu. Meningitis usually peaks in late winter and early spring and its flu-like symptoms make diagnosis difficult. The bacteria may be carried in the nose or throat without symptoms. Meningococcal may also cause other body infections instead of meningitis, such as septic arthritis, brain inflammation, and pneumonia. Because the disease progresses rapidly, often in as little as 12 hours, students are urged to seek medical care immediately if they experience two or more of these symptoms concurrently.

Treatment with antibiotics should begin as soon as the diagnosis is considered.

Vaccination is available to protect against four of the five most common strains of bacteria that cause meningitis in the United States --Types A, C, Y, and W-135. These types account for nearly two thirds of meningitis cases among college students. The vaccine is 85% effective against these four groups and provides protection for approximately three to five years. The current vaccine does not protect against group B bacteria strain. The vaccine is very safe; adverse reactions are mild and infrequent, consisting primarily of redness and pain at the injection site lasting up to two days.

The Centers of Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommends that college students, particularly freshmen living in residence halls, be educated about meningitis and the benefits of vaccination. This recommendation is based on recent studies showing that college students living in residence halls, particularly freshmen, have a six-fold increased risk of contracting meningitis over other college students. The recommendation further states that information about the disease and vaccination is appropriate for other undergraduate students who also wish to reduce their risk for the disease. To learn more about meningitis and the vaccine, we encourage you to visit the CDC website, consult your health care provider, or you may contact our Immunization Office by calling 919.515.4302. For more information please visit the following link!

<https://www.immunize.nc.gov/family/vaccines/meningococcal.htm>

## ***Influenza Disease***

For more information please visit the following link: <https://www.immunize.nc.gov/family/vaccines/influenza.htm>

## ***Human Papillomavirus (HPV)***

For more information please visit the following link: <https://www.immunize.nc.gov/family/vaccines/hpv.htm>