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

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

Wake Forest University
2021-22 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 Students may be withdrawn from the university 30 days after classes begin if the mandatory immunization and TB requirements have not been met.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 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:

1. Have a doctor's office, clinic or health department complete the Immunization Form.
2. Complete the Tuberculosis Questionnaire - all incoming students must be screened for Tuberculosis risk factors through a screening questionnaire
3. The completed Immunization Requirements Form and TB Screening Questionnaire must be submitted by to hiif@wfu.edu or uploaded through your Student Health Portal.

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 to have a copy sent to our immunizations department. Records must include clinic address.
- 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 email or student portal secure message if additional information is needed. Keep a copy for your records. There are occasions when you may need to resubmit your documentation.

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.

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Deadline: Fall admission: July 1, Spring admission: January 1, Summer admission: May 1.

Do not submit until all forms are completed.

To be completed by student (use black ink if by hand)

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

Permanent Address:_____

Cell Phone:_____ Email Address:_____

Student Health uses a text message service to remind of appointments & messages that the providers send.
If you do not want this service please check box: ☐

Sex assigned at birth: Female ☐ Male ☐ Intersex ☐ Marital status: Single ☐ Married ☐ Domestic Partner ☐

Class you are entering: Fr. ☐ Soph. ☐ Jr. ☐ Sr. ☐
Graduate School of Arts & Sciences ☐ School of Business Graduate School ☐
School of Law ☐ School of Divinity ☐ Year: _____

Semester entering: Fall ☐ Spring ☐ Summer ☐ Previously enrolled at WFU? Yes ☐ No ☐

In case of emergency, contact:

Name:_____ Relationship: _____

Cell Phone:_____ Home Phone: _____ Bus. Phone: _____

Address: _____ City/State: _____

Zip:_____ Email address:_____

Health Insurance Information Required or Submit Copy of Both Sides of Insurance ID Card

If you are enrolled in Student Blue and have not have received your information yet, Please write Student Blue on Insurance Co. line. You must visit sip.studentlife.wfu.edu to complete the health insurance enrollment/waiver form, in addition to completing this section.If you have questions about this process, email to sip@wfu.edu.

Insurance Company:_____Subscriber's ID No.:_____Group No.:_____Date of Birth:___/___/___

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

Address of Ins. Co.:_____

Important Information—Please read and sign below:

Authorization and Consent: If the student is under the age of 18, a parent or guardian must also sign. I agree that the attending physician or whomever he or she may designate may evaluate and treat all 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.

_____ Date_____/_____/_____

Signature of Student (must be printed and signed)

_____ Date_____/_____ /_____

Signature of Parent/Guardian, if student under age 18

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

Family History

	Age	State of Health	Occupation	Age of Death	Cause of Death
Parent					
Parent					
Brother(s)					
Sister(s)					

Family Medical History

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		
Are you adopted?		

Personal History (check all that apply)

Are you allergic to:

Penicillin	
Sulfonamides	
Peanuts	
Bees, wasps	
Other medications/foods	
Specify	
Do you receive allergy injections?	

Have you had:

Mononucleosis	
Chickenpox	
Hepatitis B	
Hepatitis C	
HIV	
Hearing disabilities	
Vision problems	
Corrective lenses	
Asthma	

Have you had:

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	
Migraines or chronic headaches	
Neurological disorder	
Seizures	
Alcohol abuse problems	
Other drug use problems	

Have you had:

Smoking/tobacco use	
Cancer	
Chronic medical condition	
Surgery or serious injury	
Serious head injury	
Concussion	
Mobility disorder	
Organ loss	

Other Mental Health Conditions

Anxiety	
ADD, ADHD	
Depression	
Diagnosed learning disorder	
Eating disorder	
Victim of personal or sexual assault	

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A. Have you received treatment or counseling for a psychiatric or psychological problem (e.g. depression, eating disorders, anxiety)?

B. Have you had any illness or injury or been hospitalized other than already noted?

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?

Will you be participating on a WFU NCAA athletic team? Yes ☐ No ☐ If so, which sport?_____

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 sent 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 the clinic address.
- Previous College or University Records: Your immunization records do not transfer automatically. You must request to have a copy sent to our immunizations department. Records must include clinic address.

College / University Vaccines and Number of Dose Requirements

VACCINE/ NUMBER OF DOSES REQUIRED BEFORE SCHOOL ENTRY*

Diphtheria, tetanus and pertussis[1]	3 doses
Polio[2]	3 doses
Measles[3]	2 doses
Mumps[4]	2 doses
Rubella[5]	1 dose
Hepatitis B (Hep B)[6]	3 doses
Varicella[7]	2 doses
Meningococcal: Quadrivalent ACYW-135[8]	1 dose (on or after 16th birthday)
COVID-19	1 dose or 2 doses

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.
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.
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.
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. Individu-als that entered school, college, or university before July 1, 2008 are not required to receive the second dose of mumps vaccine.
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.
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.
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.
8) Meningococcal Quadrivalent ACYW-135 is required of all undergraduate students. One dose on or after the 16th birthday. Recommended for graduate and professional students. Learn about this disease at https://www.immunize.nc.gov/family/vaccines/meningococcal.htm.

* 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 a 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.

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Healthcare Provider Information
Name (print):_____
Signature: _____
Office Address: _____
_____

Date: _____
Are you the student's primary care provider?____ Yes ____ No
If no, how long have you known the student?_____

IMMUNIZATION RECORD

Section A: Required Immunizations					
Immunization Name		Date(s) Administered (MM/DD/YY)			
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. DTaP/DTP/Td (diphthe-ria/Tetanus/Pertussis or Tetanus/Diphtheria Toxoid)	Dtap				
	Dtp				
	Td				
Tdap Booster (All students MUST show proof of a Tdap booster given since 2005)					
Polio (3 doses required for students under 18 years of age)					
MMR (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)					
Measles (2 required on or after first birthday OR positive titer OR documented disease date)				Disease Date	**Titer Date & Result
Mumps (2 required on or after first birthday OR positive titer)				*Disease Date not accepted*	**Titer Date & Result
Rubella (1 required on or after first birthday OR positive titer)				*Disease date not accepted*	**Titer Date & Result
Hepatitis B Series (required if born on or after July 1, 1994)					*Titer NOT Accepted for required Hep B Series*
Varicella (required if born on or after April 1, 2001. Positive titer OR date of disease is acceptable)				Disease Date	**Titer Date & Result
Meningococcal Quadrivalent ACYW-135 (Men-actra, Menveo) A dose is required ≥ age 16 years for all undergrad-uates. Meningococcal B vaccine DOES NOT fulfill this requirement. Recommended for graduate/professional students through age 21.					

Continued on the next page.

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Section A: Required Immunizations *(continued)*					
Immunization Name		Date(s) Administered (MM/DD/YY)			
COVID-19	Moderna				
	Pfizer				
	J&J Janssen				

Section B: Recommended Immunizations					
Immunization Name		Date(s) Administered (MM/DD/YY)			
Hepatitis A					
Human Papillomavirus (HPV)	Cervarix				
	Gardasil				
	Gardasil-9				

Section C: Recommended Immunizations for Certain Patients/Medical Conditions					
Immunization Name		Date(s) Administered (MM/DD/YY)			
Meningococcal Group B	Trumenba				
	Bexsero				
Pneumovax					
Yellow Fever					
Typhoid IM					
Typhoid Oral					
Other					

Signature of Healthcare Provider:
Name (print): _____ Signature: _____
Address/Clinic Stamp: _____
_____Phone: _____

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

SECTION A: Tuberculosis (TB) Exposure Risk

Please answer the following questions:

A. Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? ___ YES ___ NO
B. Have you been a resident or an employee at a congregate living facility, correctional facility, long term care facility, homeless shelters or health care facility with patients at an increased risk of TB? ___ YES ___ NO
C. 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

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Côte d'Ivoire
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Democratic People's Republic of Korea
Djibouti
Dominican Republic Ecuador
El Salvador
Equatorial Guinea Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Trinidad and Tobago Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

If YES, where? _____ How long?_____ Dates visited/lived _____

- If YES to any of the above questions: Wake Forest University requires TB testing within 6 months of arriving on campus. See instructions on the following page for your healthcare provider.
- If the answer to all of the above questions is NO: no further action is needed.

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If YES to any questions on the Section A: Tuberculosis (TB) Exposure Risk:

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Section B: 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) or 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
IGRA Blood Test: Date administered: ___/___/___ Result:_____

If TB test is positive, chest x-ray is REQUIRED: Date completed: ___/___/___

_____Normal _____ Abnormal (must attach radiology report)

Provider Name (print) _____

Address/Clinic Stamp: _____

Provider Signature: _____

Date: _____

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REPORT OF HEALTH EVALUATION (Not required)

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 their 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 Student Health Service and will not be released without student consent. Thank you for your cooperation in completing this form. Please complete the IMMUNIZATION RECORD AND THE TUBERCULOSIS SCREENING QUESTIONNAIRE, required by Wake Forest policy or North Carolina Law. PLEASE NOTIFY US OF ANY MEDICAL PROBLEMS THAT DEVELOP AFTER THIS EXAMINATION.

Physical Findings		Was physical examination normal? ____Yes ____No
Height	cm/in	If no, please explain abnormality:
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? — Unlimited____ Limited ____ (explain below)
- Is the patient now under treatment for any medical or emotional condition? Have you any general comments? — No____ Yes____ (explain below)

Comments:

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: lac.wfu.edu/disability-services/information-for-students/