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 | shs.wfu.edu

PLEASE MAIL ATTACHED PAGES 1-5 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.

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 physicians 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.***

Wake Forest University Student Health Service
P.O. Box 7386 | Winston-Salem, NC 27109
Office: (336) 758-5218

2015-2016 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.

Deadline: Fall enrollment-June 30, Spring enrollment-January 1, or Summer school only-May 1.
Do not submit until all forms are completed.

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

Last Name	First Name	Middle Initial	Preferred 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.
If you have questions about this process please send email to sip@wfu.edu

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: Please read and sign below. **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

_____ 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
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		
Mental health condition		
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	
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

	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.*	

	Yes
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 Initial	Preferred name	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 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 to 5, required by North Carolina Law.**

PRINT PAGES 3-5 FOR PHYSICIAN TO COMPLETE

Physical Findings		**Was physical examination normal?** ____ Yes ____ No **If no, please explain abnormality**
Height	cm/in	
Weight	kg/lb	
Pulse	bpm	
Blood pressure —systolic	mmHg	
—diastolic	mmHg	
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, food allergy, or condition that requires special housing or meal plan 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.

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

_____ _____
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

PRINT PAGE FOR PHYSICIAN 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: shs@wfu.edu **DO NOT FAX**

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

DATE FORMAT: MM/DD/YYYY

Diphtheria/Pertussis/Tetanus: Minimum of 3 doses to include a **Tdap.**

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

Booster Td _____/_____/_____ **Tdap** _____/_____/_____ **Dose must have been given after May 2005**

MMR: 2 doses are required.

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 _____/_____/_____

If given as a single antigen dose, must have 2 Measles, 2 Mumps and 1 Rubella.

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)

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

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

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

Minimum 28 days between doses 1 and 2

Minimum 8 weeks between doses 2 and 3

Minimum 16 weeks between doses 1 and 3

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

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

Recommended vaccines, but not required:

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

Hepatitis A #1_____/_____/_____ #2_____/_____/_____

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

Pneumovax: (for high risk conditions) _____/_____/_____

History of Chicken pox Disease _____/_____/_____

Not required:

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

Signature of Healthcare Provider:

Name (print)_____Address/Clinic Stamp_____

Signature:_____Phone (_____)_____

Please see the following page for Tuberculosis Screening information to be completed for ALL students

PRINT

PRINT PAGE FOR PHYSICIAN TO COMPLETE

Wake Forest University Student Health Service Office: (336) 758-5218

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

TUBERCULOSIS (TB) SCREENING: (To be completed by **the Student**)

1 Have you ever had close contact with person known or suspected to have active TB disease? **Yes**_____ **No**_____
2 Have you resided more than 30 days in a country **other than** those listed as "Low incidence" below: **Yes**_____ **No**_____

LOW INCIDENCE Countries or areas are defined as areas with reported or estimated incidence of <20 cases per 100,000 population
(Source: World Health Organization and American College Health Association Guidelines)
Albania, Andorra, Antigua, Barbuda, Australia, Austria, Bahamas, Barbados, Belgium, Canada, Chile, Cook Islands, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Lebanon, Luxembourg, Macedonia, Malta, Monaco, Montenegro, Netherlands, New Zealand, Norway, Oman, Saint Kitts and Nevis, Saint Lucia, Samoa, San Marino, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Syrian Arab Republic, Tonga, United Arab Emirates, United Kingdom, United States of America.

3. Have you been a resident and/or employee of high-risk congregate settings?
(e.g. correctional facilities, long-term care facilities and homeless shelters)? **Yes**_____ **No**_____
4. Have you volunteered or worked with clients who are at increased risk for active TB? **Yes**_____ **No**_____
5. 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, such as medically underserved, low-income, or abusing drugs or alcohol? **Yes**_____ **No**_____
6. Have you ever had a positive TB skin or blood test? **Yes** _____ **No** _____

If the answer is YES to any of the above questions, Wake Forest University requires that you receive TB testing as soon as possible but should be within 6 months prior to the start of the semester in which you are entering.
If the answer to all of the above questions is NO, no further testing or further action is required.

TUBERCULOSIS (TB) RISK ASSESSMENT (To be completed by **health care provider**)

Clinicians should review and verify the information below. Persons answering YES to any of the questions in the TB SCREENING 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**_____

History of BCG vaccination? (If yes, consider IGRA if possible) **Yes**_____ **No**_____

TB Screening Test:

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

If the TB test is **positive:** Chest x-ray is required if tuberculin test is positive Date done:_____/_____/_____ ☐ Normal ☐ Abnormal
If known to be tuberculin positive or if the test is positive, attach record of treatment.

Signature of Healthcare Provider:

Name (print)_____Address/Clinic Stamp_____

Signature_____ Date_____

PRINT