



**AVOID ACADEMIC WITHDRAWAL  
SUBMIT YOUR FORM PRIOR TO COMING TO SCHOOL**

**Student Medical Form**

Health and Wellness Center  
(704) 825-6877  
FAX (704) 825-6878

Detach This Page

North Carolina state law (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 required by law. *REGISTRATION WILL BE CANCELED AND THE STUDENT ACADEMICALLY WITHDRAWN* if the immunization documentation is not received by the Student Health and Wellness Center.

High Schools and universities do not automatically send immunization records to the Student Health Center. You must request that they be sent.

Administrative offices do not forward immunization records that are attached to transcripts. You must have them sent directly to the Student Health Center.

*Exempt students: All classes after 3:30 p.m.; all classes off campus; four hours or fewer per semester; or weekend classes only.*

**INSTRUCTIONS:**

1. Write your name, social security number, and date of birth on each page and any attachments. (Do this prior to taking the form to your physician or health clinic.)
2. Fill in the medical history form and sign on the designated line. A physical exam is NOT required.
3. Compare your immunization records with the chart titled Section A on the next page.
4. Have your physician or health department give you any needed immunizations so that you are in compliance with your age group in Section A. The signature of a physician, nurse practitioner or physician assistant or health department stamp is required at the bottom of the page.
5. Turn to the back of the form, fold form in half, staple or tape, place postage in the corner and send.

**Belmont Abbey College Student Health and Wellness Center  
100 Belmont-Mt. Holly Road • Belmont NC 28012**

## GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

**IMPORTANT** – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (Be certain that your name and Social Security/ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. **Keep a copy for your records.**)

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

<b>SECTION A: IMMUNIZATION REQUIREMENTS ACCORDING TO AGE</b>	
<b>I. STUDENTS 17 YEARS OF AGE OR YOUNGER</b>	<b>II. STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER</b>
Vaccine Required	Vaccine Required
3 DTP ( <i>Diphtheria-Tetanus-Pertussis</i> ) or Td ( <i>Tetanus-Diphtheria</i> ) doses. 1 Td ( <i>Tetanus-Diphtheria</i> ) dose must be within the last 10 years. 3 POLIO ( <i>oral</i> ) doses. 2* MEASLES ( <i>Rubeola</i> ) one dose on or after 12 months of age, the 2 <sup>nd</sup> after 15 months of age. (2 MMR doses meet this requirement.) 1** RUBELLA ( <i>German measles</i> ) dose. 1** MUMPS	3 DTP ( <i>Diphtheria-Tetanus-Pertussis</i> ) or Td ( <i>Tetanus-Diphtheria</i> ) doses. 1 Td ( <i>Tetanus-Diphtheria</i> ) dose must be within the last 10 years. 2* MEASLES ( <i>Rubeola</i> ) one dose on or after 12 months of age, the 2 <sup>nd</sup> after 15 months of age. (2 MMR doses meet this requirement.) 1** RUBELLA ( <i>German measles</i> ) dose. 1** MUMPS
<b>III. STUDENTS BORN PRIOR TO 1957 AND 49 YEARS OF AGE OR YOUNGER</b>	<b>IV. STUDENTS 50 YEARS OF AGE AND OLDER</b>
Vaccine Required	Vaccine Required
3 DTP ( <i>Diphtheria-Tetanus-Pertussis</i> ) or Td ( <i>Tetanus-Diphtheria</i> ) doses. 1 Td ( <i>Tetanus-Diphtheria</i> ) dose must be within the last 10 years. (If a Td booster is the only dose you document, it must be clearly marked as a booster.) 1** RUBELLA ( <i>German measles</i> ) dose.	3 DTP ( <i>Diphtheria-Tetanus-Pertussis</i> ) or Td ( <i>Tetanus-Diphtheria</i> ) doses. 1 Td ( <i>Tetanus-Diphtheria</i> ) dose must be within the last 10 years. (If a Td booster is the only dose you document, it must be clearly marked as a booster.)
<b>V. INTERNATIONAL STUDENTS</b>	
Vaccine Required	
Vaccines are required according to age (refer to appropriate box). Additionally, International students are required to have a TB skin test and negative result within the 12 months preceding the first day of classes (chest x-ray required if test is positive).	

- \* Must repeat Rubeola (measles) vaccine if received even one day 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 disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from physician, is not acceptable.

<b>SECTION B:</b>	These vaccines are <b>RECOMMENDED</b> . Some may be required by certain departments. Consult your college or department for specific requirements.
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<b>SECTION C:</b>	These vaccines are <b>OPTIONAL</b> .
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**IMMUNIZATION RECORD**

(Please print in black ink) To be completed and signed by physician or clinic  
A complete immunization record from a physician or clinic may be attached to this form.

Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	Social Security Number
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**SECTION A REQUIRED IMMUNIZATIONS**

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
• DTP or Td	(#1)	(#2)	(#3)	(#4)
• Td Booster				
• Polio				
• MMR (after first birthday)				
• MR (after first birthday)				
• Measles (after first birthday)			**Disease Date	****Titer Date & Result
• Mumps			*** (Disease Date NOT Accepted)	****Titer Date & Result
• Rubella			*** (Disease Date NOT Accepted)	****Titer Date & Result

**SECTION B RECOMMENDED IMMUNIZATIONS**

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

	mo./day/year	mo./day/year	mo./day/year	
• Hepatitis B series				****Titer Date & Result
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
• Meningococcal				
• Tuberculin (PPD) Test	Date read (within 12 months)	mm induration		
• Chest x-ray, if positive PPD	Date	Results		
• Treatment, if applicable	Date			

**SECTION C OPTIONAL IMMUNIZATIONS**

	mo./day/year	mo./day/year	mo./day/year
• Haemophilus influenzae type b			
• Pneumococcal			
• Hepatitis A series			
• Typhoid (specify type)			
• Other			

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner

Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Area Code/Phone Number

Office Address

City

State

Zip Code

\*\* Must repeat Rubeola (measles) vaccine if received even one day 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 physician, is not acceptable.

\*\*\*\* Attach lab report.

Do Not Write in This Space

**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 CODE \_\_\_\_\_ AREA CODE/PHONE NUMBER \_\_\_\_\_

DATE OF BIRTH (mo/day/yr) \_\_\_\_\_ GENDER  M  F MARITAL STATUS  S  M  OTHER \_\_\_\_\_

CLASS YOU ARE ENTERING (circle): FR. SO. JR. SR. GRAD. PROF.	PREVIOUSLY ENROLLED HERE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATES _____	SEMESTER ENTERING (circle): FALL SPRING SU:MMER 1 SUMMER 2 OTHER YEAR 20_____
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HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) _____		AREA CODE/TELEPHONE NUMBER _____
NAME OF POLICY HOLDER _____	*SOCIAL SECURITY NUMBER _____	EMPLOYER _____
POLICY OR CERTIFICATE NUMBER _____	GROUP NUMBER _____	IS THIS AN HMO/PPO/MANAGED CARE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ AREA CODE/PHONE NUMBER \_\_\_\_\_

The following health history is confidential.

**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		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol or blood fat disorder				Cancer (type: _____)			
Stroke				Diabetes				Alcohol/drug problems			
Heart attack before age 55				Glaucoma				Psychiatric illness			
Blood or clotting disorder								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		Yes	No	Year		Yes	No	Year		Yes	No	Year
High blood pressure				Hay fever				Jaundice or hepatitis				Kidney stone			
Rheumatic fever				Allergy injection therapy				Rectal disease				Protein or blood in urine			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Hearing loss			
Pain or pressure in chest				Concussion				Hernia				Sinusitis			
Shortness of breath				Frequent or severe headache				Easy fatigability				Severe menstrual cramps			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Irregular periods			
Pneumonia				Severe head injury				Eye trouble besides need glasses				Sexually transmitted disease			
Chronic cough				Paralysis				Bone, joint, or other deformity				Blood transfusion			
Head or neck radiation treatments				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				Drug use			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Smoke 1+ pack cigarettes/week			
Diabetes				Pilonidal cyst				Broken bone (specify)				Regularly Exercise			
Serious skin disease				Frequent vomiting				Kidney infection				Wear Seat Belt			
Mononucleosis				Gall bladder trouble or gallstones				Bladder infection				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 _____
Name _____ Use _____ Dosage _____	Name _____ Use _____ Dosage _____

**FAMILY AND PERSONAL HEALTH HISTORY-CONTINUED** (Please print in black ink) To be completed by student

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).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and 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 describe)			
Other than for a routine check-up, 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.)			

**IMPORTANT INFORMATION...PLEASE READ AND COMPLETE**

**STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 18):**

- (A) I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I hereby give my permission to any doctor, hospital, or other medical agency to release confidentially to the Student Health Services at Belmont Abbey College any information they may have concerning my medical condition and their professional contact with me.
- (B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian, if student under age 18

\_\_\_\_\_  
Date

**PHYSICAL EXAMINATION** (Please print in black ink) To be completed and signed by physician or clinic

A physical examination is required by **some schools and/or programs** (consult your college or department for specific requirements). **If required**, it must be completed in black ink and signed by a physician or clinic.

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	*Social Security Number
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Permanent Address	City	State	Zip Code	Area Code/Phone Number
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Height \_\_\_\_\_ Weight \_\_\_\_\_ TPR \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

IF REQUIRED: Vision: Corrected Right 20/ _____ Left 20/ _____ Uncorrected Right 20/ _____ Left 20/ _____ Color Vision _____ Hearing: (gross) Right _____ Left _____ 15 ft. Right _____ Left _____	IF REQUIRED: Urinalysis: Sugar: _____ Albumin _____ Micro: _____ Hgb or Hct (if indicated) _____ STS (may be required by some departments) Date _____ Results _____ Recommendations _____
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Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

- A. Is there loss or seriously impaired function of any paired organs? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Explain \_\_\_\_\_
- B. Is student under treatment for any medical or emotional condition? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Explain \_\_\_\_\_
- C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited \_\_\_\_\_ Limited \_\_\_\_\_  
 Explain \_\_\_\_\_
- D. Is student physically and emotionally healthy? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Explain \_\_\_\_\_

• Only for Students Admitted to a HEALTH SCIENCES PROGRAM •

Based on my assessment of this student's physical and emotional health on \_\_\_\_\_, he/she appears able to participate in the activities of a health profession in a clinical setting. Yes \_\_\_\_\_ No \_\_\_\_\_ (Date) if no, please explain \_\_\_\_\_

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

Date \_\_\_\_\_

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

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

Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\*Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.