Last Name: _____ **First Name:** _____
MU Student ID#: _____ **Student Phone #:** _____
Year Attending: _____ **Fall** _____ **Spring** _____

Year Attended if Returning Student _____
Student Athlete: y/n ____ **Sport:** _____
International Student: y/n ____
Physician Assistant Student: y/n ____
Nursing Student: y/n ____
Physical Therapy Student: y/n ____
Occupational Therapy Student y/n _____

Student Health Services Office

5400 Ramsey Street
Fayetteville, North Carolina 28311-1498
Phone: (910) 630-7164 or (910) 630-7652 • FAX: (910) 630-7544

METHODIST
UNIVERSITY

Methodist University Student Health Center
IMMUNIZATION REQUIREMENTS

All students are required to submit immunization records under North Carolina Law Unless:

- · Off campus courses
- · Evening courses (Start at 5:00 PM or later)
- · No more than four traditional day credit hours
- · Weekend courses

IMMUNIZATIONS that are REQUIRED pursuant to NC state law MUST BE LISTED ON THE MU FORM AND COMPLETED BY CLINIC.

Your immunization records **do not transfer automatically** from high schools or other colleges/universities. You must request them to be sent to the Student Health Center. They will be screened carefully by this institution and if deficiencies are found the student will be notified and will be given a reasonable period to comply.

Immunizations must be incompliance ***no later than 30 day upon registering for classes.*** Students who fail to comply with these requirements will not be permitted to remain in attendance at Methodist University. This is fully enforced.

If you have any questions are need to verify that I have received your immunization record pleasefeel free to call me at 1-800-488-7110 ext. 7652.

GUIDELINES FOR COMPLETING IMMUNIZATIONRECORD

IMPORTANT

- Records must be documented in BLACK INK and all corrections must be signed.
- Submit immunizations **in English** by mm/dd/yy Example: 12/31/12

SECTION A: Undergrad Students, Physician Assistant, Physical Therapy, Athletic Training, Occupational Therapy and Nursing. Required

DTP (3Does): 3 Doses of the Tetanus/diphtheria toxoid of which one must have been within the past 10 years.

Polio (3 Doses): An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

Measles (2 Doses): An individual born prior to 1957 is not required to submit proof of immunizations. An individual may submit a titer lab report documenting that they have a protective antibody against the Measles.
Mumps (2 Doses): An individual born prior to 1957 is not required to submit proof of immunizations. An individual may submit a titer lab report documenting that they have a protective antibody against the Mumps.
Rubella (2 Doses): An individual born prior to 1957 is not required to submit proof of immunizations. An individual may submit a titer lab report documenting that they have a protective antibody against Rubella.

Hepatitis (3 Doses): An individual is not required to submit proof of vaccine if born before July 1, 1994. Any student entering in the medical fields must show proof of these vaccines or a titer lab report documenting that they have a protective antibody against Hepatitis B.

NOTE: Blood titer tests are acceptable for Measles, Mumps, Rubella and Hepatitis B. A laboratory test results must be attached.

SECTION B: Physician Assistant, Physical Therapy, Occupational Therapy and Athletic Training. Required

Varicella (2 Doses): An individual must show proof of these vaccines or a titer lab report documenting that they have a protective antibody against the Chicken Pox.
Tuberculin: An individual must show a TB skin test within the twelve months preceding before entering into the programs.
Physical: An individual is required to submit a physical within 4 months preceding entering into the program**.**

SECTION C: Nursing. Required

Tuberculin: Any individual must show a two-step TB skin test within the four months preceding entering into the program.
Physical: An individual is required to submit a physical within 4 months preceding entering into the program**.**
Influenza: must be within the current year**.**
Varicella (2 Doses): An individual entering in the medical fields must show proof of these vaccines or a titer lab report documenting that they have a protective antibody against the Chicken Pox.

SECTION D: Optional

Meningococcal (2 Doses): The CDC recommends that college students living in residence halls be educated about meningitis and the benefits of vaccination. To learn more visit the CDC website at http: www.cdc.gov

Vaccines are **OPTIONAL** or for future use.

THIS PAGE MUST BE COMPLETED BY A CLINICIAN

IMMUNIZATION RECORD **(Please type or print in black ink)**

Last Name, First Name, Middle Name	Date of Birth mo/day/year	

SECTION A: Undergrad Students, Physician Assistant, Physical Therapy Occupational Therapy, Athletic Training, and Nursing. Required

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
• DTP or Td				
• TDAP Booster				
• Polio				
• Measles (**M**MR)			Disease Date	Titer Date & Result
• Mumps (M**M**R)				Titer Date & Result
• Rubella (MM**R**)				Titer Date & Result
• Hepatitis B Series (if born after July 1,1994)				Titer Date & Result

SECTION B: Physician Assistant, Physical Therapy, Occupational Therapy and Athletic Training. The following immunization are required

	mo/day/year	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.				Titer Date & Result
• TUBERCULIN (PPD) Test **Date Results**				
Chest x-ray, if positive PPD **Date Results**				
Treatment, if applicable **Date Results**				

SECTION C: Nursing. The following immunizations are required

• Hepatitis B series				Titer Date & Result
• Varicella (chicken pox) series of two doses or Immunity by positive blood titer.				Titer Date & Result
• Two- Step TUBERCULIN (PPD) Test	First Date	First Results	Second Date	Second Results
Chest x-ray, if positive PPD **Date Results**				
Treatment, if applicable **Date Results**				
• **Influenza must be within the current year**				

SECTION D: Optional

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
• Hemophilus Influenza, b				
• Pneumococcal				
• Meningococcal				
• Hepatitis A series				
• Other				

Clinician Signature or Clinic Stamp_____ Telephone _____

Office Address_____ Date _____

Report of Medical History (Please type or print in black ink)

LAST NAME (print) FIRST NAME MIDDLE NAME

PERMANENT ADDRESS CITY STATE ZIP AREA CODE/PHONE

DATE OF BIRTH (mo/day/yr)_____ GENDER M F MARITIAL STATUS S M OTHER

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) TELEPHONE

NAME OF POLICY HOLDER EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS AREA CODE/PHONE

The following health history is confidential, does not affect your admission status and (except in an emergency situation or by court order will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY AND PERSONAL HEALTH HISTORY (Please type or print in black ink)

Has any person related by blood, had any of the following?

	Yes	No	Relationship
High blood pressure			
Stroke			
Cancer :(type)			
Heart Attack before age 55			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Blood or clotting disorder			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT_____WEIGHT_____

Have you ever had or have you now: (please check at the 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				Mononucleosis				Self-induced vomiting				Back injury			
Rheumatic Fever				Hay Fever				Frequent vomiting				Broken bones			
Heart trouble				Head or neck radiation treatment				Gall bladder trouble or gallstones				Kidney infection			
Pain or pressure in chest				Arthritis				Jaundice or hepatitis				Bladder infection			
Shortness of breath				Concussion				Rectal disease				Kidney stone			
Asthma				Frequent or severe headache				Severe or recurrent abdominal pain				Protein or blood in urine			
Pneumonia				Dizziness or fainting spells				Hernia				Hearing loss			
Chronic cough				Sever head injury				Easy fatigability				Sinusitis			
Tuberculosis				Paralysis				Anemia or Sickle cell anemia				Severe menstrual cramps			
Tumor or cancer (specify)				Epilepsy/Seizures				Eye trouble besides needing glasses				Irregular periods			
Malaria				Disabling depression				Bone, joint or other deformity				Blood transfusion			
Thyroid trouble				Excessive worry or anxiety				Shoulder dislocation				Smoke 1+ pack cigarettes/week			
Serious skin disease				Ulcer (duodenal or stomach)				Knee problems				Diabetes			
Alcohol/drug use				Intestinal trouble				Recurrent back pain				Anorexia/Bulimia			
Sexually transmitted disease				Pilonidal cyst				Neck injury				Allergy injection therapy			

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and non-prescription that you use and indicate how often you use them.

Name_____Use_____Dosage_____ Name_____Use_____Dosage_____

Name_____Use_____Dosage_____ Name_____Use_____Dosage_____

PERSONAL HEALTH HISTORY (Please type or print in Black ink)

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 first occurred, and if the experience has occurred more than once.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
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 any loss or seriously impaired function of any paired organs? (Please describe)			
Other then for a routine check-up, have you seen a physician or health-care professional in the last 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: I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court order. However, if I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission for Student Health Services to release information from my medical record to a physician, hospital, or other medical agency involved in providing me with emergency treatment and/or medical care.

_____ _____

Signature of Student Date

PARENT/GUARDIAN OF STUDENT UNDER 18: I hereby authorize any medical treatment for my son/daughter which may be advised or recommended by the physicians of the Student Health services.

_____ _____

Signature of Parent/Guardian if under 18 Date

PHYSICAL EXAMINATION (Please type or print in black ink.)

- **A PHYSICAL EXAMINATION IS REQUIRED FOR ALL STUDENT ATHLETES.**

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	* Social Security Number
Permanent address	City	State	Zip Code	Area Code/Phone Number

Height_____ Weight_____ TPR_____/_____/_____ BP_____/_____

Vision: Corrected Right 20/_____ Left 20/_____ UnCorrected Right 20/_____ Left 20/_____ Color Vision_____

Hearing: (gross) Right_____ Left_____ 15 ft. Right_____ Left _____

Urinalysis: Sugar:_____ Albumin_____ Micro_____ Hgb or Hct (if indicated)_____

Are there abnormalities? If so, describe fully	Yes	No	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 STUDENT ATHLETES

Based on my assessment of this student's physical and emotional health on_____(he / she) appears able to participate in intercollegiate sports Yes_____ No_____ If No, please explain _____

ONLY FOR STUDENTS ADMITTED TO A HEALTH CARE PROFESSION

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_____ If No, please explain _____

Signature of Clinician Date

Print Name of Clinician Date

Office Address Area Code/Phone Number

*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

Required for Student-Athletes Only:

For participation in intercollegiate athletics (including dance and cheerleading), all student-athletes must verify their sickle cell trait status prior to participation in a sport without regard to risk factors. Student-athletes will be unable to participate without this verification. If the perspective student athlete has previously undergone testing, most were tested at birth, contact their pediatrician (at birth) for a copy of test results. Submit these results along with the physical exam form. A copy of documentation from previous test will be excepted as a substitute for a signature below. If not previously tested for the trait, please conduct testing at this time, and record results in the section below.

Sickle Cell Trait Positive_____ Sickle Cell Trait Negative_____ Date of Test_____

Physician / Medical Provider_____ Date _____

Address_____ Phone _____

A waiver is available for student-athletes who do not wish to undergo sickle cell trait testing. If you have a question or concern or would like more information on sickle cell trait testing, the testing waiver and the NCAA requirement, please contact the Head Athletic Trainer at telephone number 910-630-7572.