

Student Medical Form (pages 13-16)

Instructions for Completing Medical Form

NOTE: You will **NOT** be allowed to complete registration for classes until your medical form is completed and returned.

READ CAREFULLY

- 1. Complete pages 14 and 15 of the form and as much of the section on page 16 as you can before seeing your physician.**
 - Records must be documented in black ink and all corrections must be signed.
 - All dates must include month, day and year of administration.
- 2. Ask your physician or your county health department to bring your immunizations and tuberculin skin test up to date if necessary. Keep in mind that:**
 - All required immunizations listed (including tetanus immunization within the past 10 years) are mandatory for enrolling at Meredith;
 - A tuberculin skin test within 1 year prior to your enrollment at Meredith is also required. Please have tuberculin skin test read before submitting form.
 - Immunizations that are required pursuant to NC state law:
 - Students born in 1957 or later and 18 years of age or older:
 - 3 DTP (Diphtheria, Tetanus, Pertussis) or Td (Tetanus, Diphtheria) doses; one Td or Tdap booster must have been within the past 10 years.
 - 2 Measles (Rubeola), 2 Mumps, 1 Rubella (MMR is preferred vaccine)
 - Immunizations records can be obtained from:
 - Your pediatrician's or family physician's office
 - Your high school
 - The local department of health
 - For transfers, records from previous college/university
 - CDC: <http://www.cdc.gov/vaccines/recs/immuniz-records.htm>
- 3. Ask your physician to review the information you provided and to complete the remainder of the form. Make sure that he/she:**
 - Reviews the immunization history and updates all necessary immunizations.
 - Signs the bottom of page 16 certifying that your medical history, immunizations and physical examination are complete.
 - Students who plan to play intercollegiate sports must have their physical dated after April.
- 4. Transfer students must complete pages 14 and 15 of this form and in lieu of another physical exam may request and forward copies of health records from the institution in which currently enrolled to the address above.**
- 5. Check your medical form for completion, sign and mail to the address above by June 1. Questions regarding this form should be directed to Health Services, (919) 760-8535.**

Student Medical Form (continued)

Report of Medical History

IMPORTANT: This form must be completed, returned to the College and found complete by Health Services before you can register for classes. Information supplied will be used as an aid in providing necessary care while you are a student. The information is strictly for the use of Health Services and will not be released to anyone without your knowledge and written consent.

Last Name (print)	First Name	Middle Name	Last four digits of Social Security Number
Permanent Address		City	State ZIP
Area Code/Telephone		Date of Birth (mo/day/yr)	
Cell phone (student)		Student's email (please print)	
Marital Status: <input type="radio"/> S <input type="radio"/> M <input type="radio"/> Other		Class You are Entering: <input type="radio"/> FR <input type="radio"/> SO <input type="radio"/> JR <input type="radio"/> SR	
Previously Enrolled Here: <input type="radio"/> Yes <input type="radio"/> No		Semester Entering: <input type="radio"/> Fall <input type="radio"/> Spring Year 20____	
Hospital/Health Insurance (Name and Address of Company)			Policy Number
Name of Policy Holder		Employer	
Name of Person to Contact in Case of an Emergency			Relationship
Address		(Home) Area Code/Telephone	(Work) Area Code/Telephone
(Cell) Area Code/Telephone		Emergency Contact Email	

Family & Personal Health History

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.

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 or clotting disorder			
Stroke				blood fat disorder				Alcohol/drug problems			
Cancer (type:)				Diabetes				Psychiatric illness			
Heart attack before age 55				Glaucoma				Suicide			

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

Student Medical Form (continued)

(Family & Personal Health History continued)

Student Name _____

Please describe any conditions or disabilities that would exclude participation in physical education:

Do you exercise three or more times per week? Yes No

Do you use a seatbelt on a regular basis? Yes No

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

Brand Name	Use	Dosage	Brand Name	Use	Dosage

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.

	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 because of 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, 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 hereby authorize medical treatment which may be advised or recommended by the medical personnel of the Student Health Services of Meredith College. If serious illness of any kind requires hospitalization, emergency treatment or major surgery, I understand that my parents or guardian will be contacted by telephone if at all possible. If they cannot be reached, emergency treatment may be given as necessary for my well-being.

Signature of Student _____

Date _____

Signature of Parent or Guardian *(if under 18 years of age)* _____

Student Medical Form (continued)

Report of Health Evaluation

STUDENT MEDICAL FORM *✓ checklist*

- Ensure all immunizations are listed (according to NC State law)
- Make sure the physician completes and signs physician form
- Enclose a copy of the front and back of insurance card
- Make sure your Tuberculin (PPD) test is current (within 12 months)
- Make a copy for your records

Last Name _____ First Name _____ MI _____ Date of Birth _____

TO THE EXAMINING PHYSICIAN: Please review the student's medical history, immunization history, proof of PPD, and then complete the examination and general comments portion of this form.

Vaccine	Series Date	Series Date	Series Date	Booster Date	Booster Date	<p>The North Carolina Immunization Law requires that students entering college present to the school authorities immunization certification.</p> <p>Please note that if this requirement is not met, dismissal from school 30 days after registration is mandatory under the law.</p> <p>Please Do Your Part to make sure you have the minimum immunization required before sending in your form.</p>
DTP (Date of series required)	#1	#2	#3	#4		
Tdap (Booster within ten years)		Required				
Polio, oral						
Hepatitis B (recommended)						
Measles (Rubeola) on or after 1st birthday	#1	Booster required: #2				
Mumps		Booster required:				
Rubella (German measles)		Booster required:				
Meningococcal (recommended)						
Gardasil - HPV vaccine (recommended)	#1	#2	#3			
Tuberculin (PPD) Test (within 12 months)	Date given Date read	Required		Results	mm induration	
Chest x-ray, if positive PPD	Date Results					
Treatment, if applicable	Date					

Height _____ Weight _____ BP _____ Pulse _____ Temp. _____

Vision R 20/ _____ L 20/ _____ Corrected _____ Hearing (Gross) R _____ L _____

Are there abnormalities of the following systems?

System	Yes	No	System	Yes	No	<p>Urinalysis</p> <p>Sugar _____</p> <p>Albumin _____</p> <p>Micro _____</p> <p>Sp. Gr. _____</p>	<p>Blood</p> <p>Hct. _____</p> <p>Hgb. _____</p>
1. Head, Ears, Nose, Throat			9. Musculoskeletal				
2. Eyes—Fundi			10. Metabolic/Endocrine				
3. Respiratory			11. Neuropsychiatric				
4. Lymphatic			12. Skin				
5. Cardiovascular			Describe fully.				
6. Gastrointestinal							
7. Hernia							
8. Genitourinary							

General Comments (diagnosis, recommendation, etc.)

Physical Activity? Unlimited Limited

Explain: _____

Is this student now under treatment for any medical or emotional conditions? Yes No

Explain: _____

Name of Physician (Print) _____ Date _____ Signature of Physician _____

Office address _____ Area Code/Office Telephone _____