MEREDITH COLLEGE

Raleigh, North Carolina

Student Medical Form (pages 13-16)

Instructions for Completing Medical Form

Upon completion of pages 14-16 use enclosed envelope to return all pages to:

Meredith College
Office of Admissions
3800 Hillsborough Street
Raleigh, NC 27607-5298

NOTE: The deadline for submssion of the Student Medical Form is June 1. Students will be withdrawn from the College 30 days after classes begin if immunization requirements have not been met and the Student Medical Form has not been returned to the Office of Admissions. Please submit pages 13-16 together after all forms are complete.

READ CAREFULLY

1. **Complete pages 14 and 15 of the form and as much of the section on page 16 as you can before visiting your physician.**
   - Records must be documented in black ink and all corrections must be signed.
   - All immunization dates must include month, day and year of administration.
2. **Make sure to read page 18 concerning meningococcal disease and new vaccine recommendation.**
3. **Ask your physician or your county health department to bring your immunizations and tuberculin skin test up to date if necessary. Please refer to www.immunize.nc.gov/schools.**
   Keep in mind that:
   - All **required** immunizations listed are mandatory for enrolling at Meredith;
   - A **tuberculin skin test** within 1 year prior to your enrollment at Meredith is also required. Please have your tuberculin skin test read before submitting this form.
   - Immunizations that are required pursuant to NC state law:
     - All students: Three doses of Tetanus/Diphtheria toxoid; one of which must be Tetanus/Diphtheria/Pertussis.
     - Students born in 1957 or later: 2 Measles (Rubeola), 2 Mumps, 1 Rubella
     - Students born before 1957: 2 Measles (Rubeola) and 2 Mumps or proof of immunity by titer with lab report. Rubella is NOT required for students 50 years of age or older.
     - Students under the age of 18: Polio series
     - Students born after 7/1/1994: 3 Hepatitis B doses
     - If immunizations are unavailable, you may submit a titer for proof of immunity, attach with the lab report.
   - Immunizations records can be obtained from:
     - Your pediatrician's or family physician's office
     - Your high school
     - The local department of health
     - For transfer students, records from previous college/university, including updates as needed
     - For more information on how to obtain vaccine records please visit:
       CDC: http://www.cdc.gov/vaccines/recs/immuniz-records.htm
4. **Ask your physician to review the information you provided and to complete and sign 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, Tb skin test and physical examination are complete.
   - Students who plan to play intercollegiate sports must have their physical dated after April.
5. **Transfer students must complete pages 14 and 15 of this form. Students must either complete page 16 or may request and forward copies of your physical exam, immunizations, and tuberculin skin test from the former institution (updates may be required).**
6. **Enclose a copy of the front and back of insurance card.**
7. **All full-time undergraduate students must complete the insurance waiver online (See page 17)**
8. **Check your medical form for completion, sign page 15 and mail all pages together to the address above by June 1 (April 15 for Summer entry transfers). Questions regarding this form should be directed to Health Services at (919) 760-8535, or healthcenter@meredith.edu.**

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MEREDITH COLLEGE

Raleigh, North Carolina

Student Medical Form (continued)

Report of Medical History

IMPORTANT: Pages 14-16 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.

REFER TO THE CHECK LIST ON PAGE 16

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) Age

Cell phone (student) Student's email (please print)

Marital Status: ◯ S ◯ M ◯ Other

Class You are Entering: ◯ FR ◯ SO ◯ JR ◯ SR

Previously Enrolled Here: ◯ Yes ◯ No

Semester Entering: ◯ Fall ◯ Spring Year 20____

Hospital/Health Insurance (Name and Address of Company) Subscriber/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 fat disorder				Blood or clotting disorder			
Stroke								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												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												Hearing loss			
Chronic cough				Dizziness or fainting spells				Hernia				Sinusitis			
Tuberculosis				Severe head injury				Easy fatigability				Severe menstrual cramps			
Tumor or Cancer (specify)				Paralysis				Anemia or Sickle Cell Anemia				Irregular periods			
Malaria				Epilepsy/Seizures				Eye trouble besides need for glasses				Blood transfusion			
Thyroid trouble				Disabling depression								Smoke 1+ pack cigarettes/week			
Serious skin disease				Excessive worry/anxiety				Bone, joint or other deformity							
Alcohol/drug abuse				Ulcer (duodenal or stomach)				Shoulder dislocation				Diabetes			
Sexually transmitted disease				Intestinal trouble				Knee problems				Anorexia/Bulimia			
				Pilonidal cyst				Recurrent back pain				Allergy injection therapy			
Mononucleosis				Self-induced vomiting				Neck injury				Chickenpox (Disease)			

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Upon completion of pages 14-16 use enclosed envelope to return all pages to:

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Office of Admissions
3800 Hillsborough Street
Raleigh, NC 27607-5298

Student Medical Form (continued)

(Family & Personal Health History continued)

Student Name _____
Last Name First Name Middle Name

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

_____

Please list all medications including those used for contraception, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

Brand Name	Use	Dosage	Brand Name	Use	Dosage
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.

Adverse Reaction to:			
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

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)*

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MEREDITH COLLEGE

Raleigh, North Carolina

STUDENT MEDICAL FORM ✓*Checklist*

- ◯ Ensure all required immunizations are listed (according to NC State law)
- ◯ Make sure the physician completes and signs the physical exam form, page 16
- ◯ Enclose a copy of the front and back of insurance card
- ◯ Make sure your Tuberculin (PPD) test is current (within 12 months)
- ◯ Complete the insurance waiver process online. See page 17
- ◯ Read about meningococcal disease and vaccine. See page 18
- ◯ Make a copy of pages 14-16 for your records

Student Medical Form (continued)

Report of Health Evaluation

Last Name **First Name** **MI** **Date of Birth**

Immunizations—ALL students must complete *(*If Titers are necessary, please attach lab report)*

Vaccine	Series Date	Series Date	Series Date	*Titer Date
DTP (Date of series required)	#1	#2		
Tdap (Booster within ten years required)				
Polio (required if under 18 years of age)	#1	#2	#3	
Hepatitis B (required if born after 7/1/94)	#1	#2	#3	
Measles (Rubeola) on or after 1st birthday	#1	Booster required: #2		
Mumps	#1	Booster required: #2		
Rubella (German measles)	#1			
Meningococcal (recommended) See page 18				
Gardasil - HPV (recommended)	#1	#2	#3	
Varicella/Chicken Pox (recommended)	#1	#2		

Tuberculin (PPD) Test **(required within 12 months)**	Date given Date read	**Required** **Results** **mm induration**
Chest x-ray, if positive PPD	Date	**Results - Attach copy of the report**
Treatment, if applicable	Date	

The North Carolina Immunization Law *requires that students entering college present to the school authorities immunization certification.*

Please note that if this requirement is not met, dismissal from school 30 days after registration is mandatory under the law.

Please Do Your Part *to make sure you have the minimum immunizations required before sending in your form. Refer to www.immunize.nc.gov/schools.*

Verified by Physician or Health Department Stamp (Mandatory) Date

Physical Examination (All students under age 23, including transfers):

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.

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
1. Head, Ears, Nose, Throat			9. Musculoskeletal		
2. Eyes—Fundi			10. Metabolic/Endocrine		
3. Respiratory			11. Neurological		
4. Lymphatic			12. Skin		
5. Cardiovascular			13. Psychiatric		
6. Gastrointestinal			Describe fully.		
7. Hernia					
8. Genitourinary					

General Comments (diagnosis, recommendation, etc.)

Physical Activity? ◯ Unlimited ◯ Limited

Explain: _____

Is this student now under treatment for any medical and/or emotional condition? ◯ Yes ◯ No

Explain: _____

Print Name of Physician, Physician Assistant or Nurse Practitioner Date Signature of Physician, PA or NP

Office address Area Code/Office Telephone

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MEREDITH COLLEGE

Raleigh, North Carolina

Insurance Waiver

Meredith College values the health and welfare of its students. To serve the health needs of our student community, Meredith requires health insurance as a condition of enrollment for all full-time undergraduate (12 credit hours or more) students to assure that students have access to health care services beyond what is available on campus.

Students who have health insurance:

- If you have health insurance and wish to opt out of the plan that Meredith College offers, complete the waiver at meredith.edu/on_campus_services/health_services.
- The waiver will be available starting in June 2016. If this form is not completed by September 14, 2016 your student account will automatically be charged for the insurance plan Meredith is offering.

Students who do not have health insurance:

- Purchase a health insurance policy and complete the waiver at meredith.edu/on_campus_services/health_services. The waiver will be available starting in June 2016. The form needs to be completed by September 14, 2016 or your account will automatically be charged for the insurance plan Meredith is offering; **OR**
- Do not complete the waiver and automatically be enrolled in the plan Meredith College offers. Your student account will be charged on your first bill.

Students should check with their insurance provider to see if coverage is appropriate for Raleigh, North Carolina and is an active, credible plan.

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Some Factors to Consider in Evaluating Your Current Health Insurance Plan:

1. Does your health insurance plan provide medical benefits for you while at Meredith?
2. Does your current plan provide benefits from August 1, 2016 – July 31, 2017?

Summary of Meredith's Current 2015-16 Plan

Insurance Carrier: BlueCross BlueShield of North Carolina

Benefit Period: This plan provides benefits to students from August 1, 2015 through July 31, 2016.

Cost of Plan: The cost for the current benefit period is $2,164. The cost may vary depending on the plan Meredith offers in 2016-17.

Current Benefit Summary for in-network providers

- $25 copay for Primary Care Provider
- $50 copay for specialist
- No out-of-pocket cost for preventative care, routine exams, immunizations and routine eye exams
- Prescription benefits
  - $15 for Tier 1 medications for 31 day supply
  - $45 for Tier 2 medications for 31 day supply
  - $60 for Tier 3 medications for 31 day supply
  - 25% coinsurance for Tier 4 medications (specialty brands), no maximum
- Psychotherapy/Mental Health benefit, $50 copay
- $50 co-pay per visit for preferred provider urgent care visits
- $300 co-pay for emergency department

To view Meredith's current plan for the 2015-16 academic year, please go to meredith.edu/on_campus_services/health_services. The plan for 2016-17 will be similar to the current plan.

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MEREDITH
COLLEGE

Raleigh, North Carolina

Important Information about Meningococcal Disease

Neisseria menigitidis is the bacterium responsible for meningococcal disease. This particular bacterium can live unnoticed in individuals ("carrier state") with no symptoms. Occasionally, the bacteria will invade the bloodstream or other body tissues and cause meningococcemia, meningitis, pneumonia or pharyngitis (sore throat). Individuals who have had close, intimate contact with a "carrier" or with an individual who has one of these illnesses may become infected with the bacteria also. Even if treated promptly, meningococcal disease may progress rapidly and cause serious medical problems including death.

Meningococcal disease incidence has decreased since 2000, and incidence for serogroups C and Y, which represent the majority of cases of vaccine-preventable meningococcal disease, are at historic lows. However, the peak in disease among persons aged 18 years has persisted, even after routine vaccination was recommended in 2005. Freshmen, particularly those who live in residence halls, constitute a group at modestly increased risk of meningococcal disease relative to other persons their age. (Other undergraduate students wishing to reduce their risk of meningococcal disease can also choose to be vaccinated.)

There are two vaccines against N. meningitidis available in the United States, Menveo by Novartis; and Menactra by Sanofi Pasteur. Both vaccines can help to prevent 4 types of meningococcal disease (types A, C, Y, and W-135). Meningococcal vaccines cannot prevent all types of the disease (e.g. serotype B), but they do help to protect many people who might become sick if they didn't get the vaccine.

For more information on Meningococcal Disease, please go to the CDC website at http://www.cdc.gov/meningitis/bacterial.html.

A Meredith student who chooses to receive the vaccine should get it from their family physician or local health department. The vaccine is available at Wake County Department of Health and Human Services.

MENINGOCOCCAL VACCINE RECOMMENDATION, as of January 28, 2011

Most students received one meningococcal vaccine at age 11 or 12. Originally this was thought to provide protection to students throughout their high school and college years. Recent research has found that persons immunized at age 11 or 12 might have decreased protective immunity by ages 16 – 21 years, when their risk for disease is greatest.

Meningococcal Meningitis Vaccine Booster: A booster dose is now recommended for those 16 years of age who received the initial dose at age 11-12. If the initial dose was given at 13-15 years, the booster dose should be given at 16-18 years of age. If the initial dose was given age at 16 years or older, no booster is needed, except where there is continuing risk.

Please check with your physician to see if a meningitis booster is needed before coming to Meredith.

For more information on this latest recommendation please refer to the following CDC web address. http://www.cdc.gov/vaccines/vpd-vac/mening/default.htm

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