HEALTH INFORMATION FORMS

To be completed by student. Please print in black ink.

LAST NAME _____FIRST _____ MIDDLE _____ __

PERMANENT ADDRESS _____

CITY _____STATE _____ZIP CODE _____STUDENT CELL _____ _

PHONE NUMBER _(____)_____ DATE OF BIRTH _____SOC. SEC. NUMBER_____

MARITAL STATUS _____ CLASS YOU ARE ENTERING (CIRCLE): FY SO JR SR

SEMESTER ENTERING (CIRCLE): FALL SPRING SUMMER 1 SUMMER 2 YEAR 20_____ GENDER: _____

INSURANCE INFORMATION

Health Insurance Requirement: Salem College requires that all students have health insurance. **All Students will be billed the $316 premium.** If you have insurance and do NOT want the Pearce and Pearce plan, you are required to fill out an on-line waiver form which will also help you assess your current plan. If your current plan meets the waiver criteria, you will not be required to purchase the policy and the charge will be removed from your account. You will receive an email during the first week of June giving you specific instructions on how to complete the online waiver, check your Salem email often for important updates from the College. By requiring every student to have adequate health insurance, we are decreasing the chance of an unexpected medical expense that might affect your ability to be successful in College.

A copy of insurance card, front and back is REQUIRED

NAME AND ADDRESS OF HEALTH INSURANCE COMPANY

_____

AREA CODE/TELEPHONE NUMBER _____

NAME OF POLICY HOLDER _____

SOC. SEC. NUMBER OF POLICY HOLDER_____-_____-_____DOB OF POLICY HOLDER _____/_____/_____

EMPLOYER _____

POLICY OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

IS THIS AN HMO/PPO.MANAGED CARE PLAN? YES NO

PERSONAL HISTORY

Do you have now or have you ever had; (circle all that apply)

1. ADD OR ADHD	11. CHRONIC HEALTH PROBLEMS	21. IMPAIRED MOBILITY/ PARALYSIS	31. PNEUMOTHORAX
2. ANEMIA	12. DEAF/ HEARING IMPAIRMENT	22. KIDNEY DISEASE	32. SEIZURE DISORDER
3. ANOREXIA/BULIMIA	13. DEPRESSION	23. LEARNING DISABILITY	33. STD
4. APPENDECTOMY	14. DIABETES	24. LOSS OF PAIRED ORGAN	34. SICKLE CELL DISEASE
5. ARTHRITIS	15. EMOTIONAL/ MENTAL ILLNESS	25. MALARIA	35. THYROID DISEASE
6. ASTHMA	16. HEART DISEASE/ PROBLEM	26. MIGRAINE/CHRONIC HEADACHE	36. POSITIVE TB TEST
7. BLIND/VISUAL IMPAIRMENT	17. HEPATITIS (TYPE_____)	27. MONONUCLEOSIS	37. TUBERCULOSIS DISEASE
8. CANCER/ MALIGNANCY	18. HIGH BLOOD PRESSURE	28. NEUROMUSCULAR DISEASE	38. ULCER/ STOMACH PROBLEMS
9. CHICKENPOX	19. HIGH CHOLESTEROL	29. PARASITE INFECTION	39. UTI/ FREQUENT
10. CROHN'S/IBS/COLITIS	20. HIV INFECTION/DISEASE	30. PHLEBITIS/ DEEP VEIN	40. OTHER

Please explain all Circled answers including dates:

_____

_____

_____

HOSPITALIZATIONS:

Please list all medical/psychiatric hospitalizations, dates, and diagnosis**:**_____

_____

GYNECOLOGICAL HISTORY

Date of last Pap smear_____Result_____Have you ever had an abnormal Pap smear_____

Have you had a Colposcopy?_____Date_____

Do you have now or have you ever had

(CIRCLE ALL THAT APPLY)

1. Irregular periods/no periods
2. Polycystic Ovary Syndrome
3. Genital Warts
4. Pelvic Inflammatory Disease (PID)
5. Genital Herpes
6. Breast Lumps/Fibrocystic Disease
7. Sexually Transmitted Infection
8. Use Contraception
9. Pregnancy (live births)_____
10. Use Oral Contraceptives
11. Abortion/Miscarriage #_____
12. Other_____

WELLNESS PROFILE

1. Do you smoke Cigarettes?_____Yes, _____No, Number per Day_____ For how many years?_____
2. Do you drink Alcohol? ____Yes___No. If yes, how often?_____When you drink, how many do you usually have_____
3. Do you now or have you ever used recreational drugs ___Yes ___No. If yes, which ones?_____ How Often?_____
4. How often do you exercise? __Never, __Daily, __3-5 times a week, __Weekly. What type of exercise_____
5. When riding in a car, what % of the time do you wear a seat belt?_____%
6. Do you perform a monthly self-breast exam? ___Yes,___No.
7. Do you follow a diet?__Yes, __No. If so what kind?_____. Are you concerned about your eating habits?___Yes, ___No.
8. How much do you weigh?_____lbs. How tall are you?_____. What is you desired weight?_____lbs.
9. Do you often have a feeling of being anxious, overwhelmed or depressed?___Yes, ___No.
10. Have you ever received counseling for emotional problems?___Yes, ___No.
11. Are you currently in counseling/therapy?___Yes, ___No. Dates of treatment_____

Medication & Allergy Information

*Please list **ALL** medications you are taking Please include prescription and non-prescription medications. This includes vitamins, minerals, herbal supplements, and allergy injections.*

MEDICATION	DOSE	USE	ALLERGY	YES	NO	EXPLAIN
1.			PENICILLIN			
2.			SULFONAMIDES			
3.			ASPIRIN			
4.			CODEINE			
5.			OTHER DRUGS			
6.			INSECT BITES			
7.			PEANUTS			
8.			OTHER FOODS			
9.			LATEX			
10.			OTHER			

IMPORTANT INFORMATION…PLEASE READ AND COMPLETE

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

(A) I have personally supplied (reviewed) the personal history 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 otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (daughter) that may be advised or recommended by the physicians of the Student Health Service.

(C) I understand that I am responsible for any charges not covered by insurance for services received by an outside provider (i.e.: laboratory, pharmacy, emergency room or consulting physician).

_____DOB____/____/_____ _____

Signature of Student Date

_____ _____

Signature of Parent/Guardian, if student under age 18 Date

EMERGENCY CONTACT INFORMATION

NAME OR PERSON TO CONTACT IN CASE OF AN EMERGENCY _____

RELATIONSHIP _____ AREA CODE/PHONE NUMBER _____

ADDRESS_____

CITY _____STATE _____ZIP CODE _____

Tuberculosis (TB) Risk Assessment Questionnaire

_____
Last Name First Name MI

____/_____/_____
Date of Birth (mm/dd/year)

1. **Are you from or have you lived for two months or more in Africa, Asia, Central or South America, or Eastern Europe?** ☐ No ☐ Yes If yes, list countries _____

2. **Have you been diagnosed with a chronic condition that may impair your immune system?**
☐ No ☐ Yes If yes, check all that apply

☐ Chronic steroid use
☐ Gastrectomy/intestinal bypass
☐ Diabetes mellitus
☐ HIV infection
☐ Crohn's disease
☐ Dialysis/Renal failure
☐ Cancer of the head or neck
☐ Rheumatoid arthritis
☐ Chronic malabsorption syndromes
☐ Silicosis
☐ Use of TNF-α antagonist
☐ Low body weight (10% or more below ideal)
☐ Leukemia, lymphoma or Hodgkin's disease
☐ Other _____

3. **Have you ever resided, worked or volunteered in any of the following facilities?**
☐ No ☐ Yes If yes, check all that apply

☐ Prison
☐ Hospital
☐ Nursing home
☐ Homeless shelter
☐ Other long term treatment center _____

4. **Do you currently have any of the following symptoms?**
☐ No ☐ Yes If yes, check all that apply

☐ Cough ≥ 3 weeks
☐ Unexplained fever
☐ Chest pain
☐ Chills
☐ Productive cough (coughing up something)
☐ Night sweats
☐ Respiratory difficulty (shortness of breath)
☐ Loss of appetite
☐ Coughing up blood
☐ Unexplained weight loss
☐ Fatigue
☐ Weakness

5. **Have you ever had contact with a person known to have active tuberculosis?**
☐ No ☐ Yes

6. **Have you ever used injection drugs?**
☐ No ☐ Yes

7. **Have you had a tuberculin skin test before?**
☐ No ☐ Yes If yes, list where given_____ Date__ /___/____(attach results)

The information above is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

_____
Signature of Student or Guardian Date

****Please take this form to with you to your doctor for your school physical****

PHYSICAL EXAMINATION

To be completed by physician or clinic and must be in ENGLISH. Please print in black ink.

Note: The student shall have a physical examination within the **12**-month period preceding the date of entrance to Salem College. Students participating in athletics **MUST HAVE** the physical exam within the 3-month period preceding the date of entrance to Salem College. Information on this form will be made available to college officials as deemed necessary for the student's well being

Last Name _____ First _____ Middle _____DOB_____/____/_____

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 _____

RPR if indicated: Date _____ Results _____
Recommendations _____

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. Neuropsychiatry			
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 _____

E. Is the student currently taking any medications to treat an emotional condition? Yes____ No_____
Please list Medications_____

F. Has the student experienced any emotional problems requiring assistance by a psychiatrist or any that might affect their adjustment to and performance at college? Yes_____ No_____
Explain_____

POTENTIAL STUDENT ATHLETES

Students are NOT eligible to practice or participate in intercollegiate sports until this form has been completed and submitted to Health Services. The athletic trainer will have access to this report of the students who elect to participate in athletics.

Based on my assessment of this student's physical and emotional health on _____, she appears able to participate in intercollegiate sports. Yes _____ No _____ If no, please explain _____

If the student is under care for a chronic condition or serious illness, please provide additional clinical reports to assist us in providing continuity of care.

Signature of Physician _____ Date _____

Print Name of Physician _____ Area Code/Phone Number _____

Office Address _____ _____

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT: The immunization requirements must be met; or, according to NC law, or 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. High School Transcript Records are not sufficient. 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.

SECTION A:	**IMMUNIZATION REQUIRMENTS ACCORDING TO AGE**
I. STUDENTS 17 YEARS OF AGE OR YOUNGER	**II. STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER**
Vaccine Required	Vaccine Required
3 DTP (Diphtheria-Tetanus-Pertussis) or Td (Tetanus-Diphtheria) doses. 1 Tdap (Tetanus-Diphtheria-Pertussis) dose must be within the last 10 years. 4 POLIO doses. 2 * MEASLES (Rubeola) one dose on or after 12 Months of age, the 2nd after 15 months of age. (2 MMR doses meet this requirement.) 1** RUBELLA (German measles) dose. 2** MUMPS 2 ***HEPATITIS B **TB Risk Assessment Form Must be completed**	3 DTP (Diphtheria-Tetanus-Pertussis) or Td (Tetanus-Diphtheria) doses. 1 Tdap (Tetanus-Diphtheria-Pertussis) dose must be within the last 10 years. 2 * MEASLES (Rubeola) one dose on or after 12 months of age, the 2nd after 15 months of age. (2 MMR doses meet this requirement.) 1** RUBELLA (German measles) dose. 2** MUMPS **TB Risk Assessment Form Must be completed**
INTERNATIONAL STUDENTS	
Vaccines Required	
Vaccines are required according to age (refer to appropriate box). Additionally, international students (if home country is **other than**: Australia, New Zealand, Canada, Western Europe or Japan) 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.

*** Hepatitis B is NOT required if any of the following occur: Born BEFORE **July 1, 1994**

SECTION B:	These vaccines are **RECOMMENDED**
SECTION C:	These vaccines are **OPTIONAL**

IMMUNIZATION RECORD

To be completed by physician or clinic. Please print in black ink. **ENGLISH ONLY**

Last Name _____ First _____ Middle _____DOB___/___/____

SECTION A: REQUIRED IMMUNIZATIONS	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
	1	2	3	4
DTP or Td (Primary Series)				
Tdap Booster				
Td Booster				
Polio				
MMR (after first birthday)				
MR (after first birthday)				
Measles (after first birthday)			***(Disease Date NOT Accepted)	****Titer Date & Result
Mumps			***(Disease Date NOT Accepted)	****Titer Date & Result
Rubella			***(Disease Date NOT Accepted)	****Titer Date & Result
Hepatitis B Series (If born **AFTER** July 1, 1994)				****Titer Date & Result
TB Assessment Form MUST be completed				

SECTION B: RECOMMENDED IMMUNIZATIONS		MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
HPV					
Varicella (chicken pox) series of two doses or immunity by positive blood titer				Disease Date	****Titer Date & Result
Meningococcal					
Tuberculin (PPD) Test **MUST COMPLETE ATTACHED FORM**					
Chest x-ray, if positive PPD	Date				
	Results				
Treatment, if applicable	Date				

SECTION C: OPTIONAL IMMUNIZATIONS	MM/DD/YY	MM/DD/YY	MM/DD/YY
Haemophilus influenza			
Pneumococcal			
Hepatitis A Series			
Typhoid (specify type)			
Flu			
Other			

Signature or Clinic Stamp Required: _____

Signature of Physician: _____ Date: _____

Print Name of Physician: _____ Area Code/Phone Number: _____

Office Address: _____

** 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.