Student Affairs
1772
SALEM
COLLEGE

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

Due to the Affordable Care Act, everyone is expected to have health insurance. Please take the time to doublecheck your insurance plan to make sure it will cover care in North Carolina. If it does not, you may wish to look into getting insurance through the federal insurance exchange [www.healthcare.gov].

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 $\geq$ 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 ____________

Sickle Cell Trait Status:________________
(Required testing for **ALL** student athletes)

Urinalysis: + - Leuk:______ Nitrate: _______ Protein: _______

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.