UNIVERSITY OF NORTH CAROLINA WILMINGTON
ABRONS STUDENT HEALTH CENTER

PRIOR TO ORIENTATION

Send completed health forms via mail, fax or email to:

University of North Carolina Wilmington
Abrons Student Health Center
601 S. College Road
DePaolo Hall, 2nd Floor
Wilmington, NC 28403

Fax: 910-962-4130
Email: immunizations@uncw.edu

If you have questions, call Student Health: 910-962-3280

UNIVERSITY OF NORTH CAROLINA WILMINGTON ABRONS STUDENT HEALTH CENTER

IMPORTANT GUIDELINES FOR COMPLETING *REQUIRED* HEALTH INFORMATION

IMMUNIZATIONS - Your immunization records do not transfer automatically from high schools or other colleges/universities, you must request them

- **Acceptable** immunization records may be obtained from any of the following but may not contain all requirements:
  - Personal Shot Record from your Physician (must be verified by a doctor's stamp or provider signature or clinic stamp
  - Permanent School Health/Medical Record - *NO transcripts*
  - Local Health Department Immunization Record
  - Previous College or University Immunization Record
  - Military Records or World Health Organization (WHO) Documents
- You may submit immunizations from the sources above or have your health care provider complete and sign the Immunization Certificate/Record. You *may not submit* the immunization certificate/record without a health care provider's signature
- You may review immunization requirements on the immunization requirements or at the North Carolina Immunization Branch: http://www.immunize.nc.gov/schools/collegesuniversities.htm

Please attach any official, legible immunization records that provide documentation making sure that your name and date of birth are on all pages. ***All documents must be in English.* Keep a copy of records for yourself.

IMPORTANT – *Immunization requirements must be met within 30 days from the date of registration, or you will be withdrawn from your classes by the Registrar without receiving course credit or monetary refund for classes.*

REPORT OF MEDICAL HISTORY

Students should complete and sign the report. If a student is *under 18*, the student should complete the form and sign as well as a parent or guardian must sign the form.

PHYSICAL EXAMINATION

A physical examination *is not required* for admission to the University. If a student is taking a physical education course and has a medical condition that may affect participation, the course instructor will request documentation of a physical within the past 14 months or require the student to get a physical.

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HEALTH INSURANCE

Students **are required** to WAIVE or ENROLL the student health insurance online through the webportal each semester:

- Undergraduate (not enrolled in Distance Education courses) enrolled in a minimum of 6 semester credit hours and Graduate students (not enrolled in Distance Education courses) enrolled in a minimum of 1 semester credit hour, AND
- Enrolled in a degree-seeking program, AND
- Eligible to pay the university Student Health Services Fee (which is part of tuition)

Visit the web portal: http://studentbluenc.com/#/uncw and follow these steps carefully:

Step 1: Register to create an account. Then login using your account user name and password.
Step 2: Have your UNCW student ID # that begins with 850.
Use your UNCW email address as the primary email address. Include a parent's email address as the secondary email so everyone receives updates.
If waiving, have your insurance card (front/back).
If enrolling, have the address where you want your insurance benefits/card sent.
Step 3: Check your UNCW email to verify your waiver status.
Step 4: Check your student account/bill to verify the health insurance charge was placed on your account or you have a credit for waiving.

Insurance Questions? Contact StudentBlue (BCBS of NC) at 1-888-351-8283 or Student Health at 910-962-3280

IMPORTANT – Insurance information you provide on the medical history, to housing, to athletics or any other entity on campus is NOT entered into the web portal and is NOT considered a waiver.

UNIVERSITY OF NORTH CAROLINA WILMINGTON ABRONS STUDENT HEALTH CENTER

IMMUNIZATION REQUIREMENTS

All students are required to submit immunizations under North Carolina Law unless:
Students reside off campus and are registered for any combination of:

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

❖ Your immunization records **do not transfer automatically** from high schools or other colleges/universities. You must request them to be sent to the Abrons Student Health Center.

Immunizations must be incompliance **no later than 30 days upon registering for classes. You will be withdrawn from your classes by the Registrar if you fail to meet the immunization requirements.*

Have your physician enter information on Immunization Certificate/Record and sign or Provide adequate, legible documents.
Submit immunizations in English by mm/dd/yyyy

DTP & Tdap – minimum 3 doses
Childhood DTP series, **Not required if proof is provided of entry to college/university prior to 07/01/2008*
Tdap (must have received 1 dose), ***Must be current with Tdap or Td, given in the past 10 years**

HEPATITIS B – 3 doses
Hepatitis A/B series is acceptable, **Not required if born before 07/01/1994*
Titers not accepted

MMR – 2 doses
1st dose must be given on or after 12 months of age
If given separately, document individually in the appropriate block

Measles
**Not required if disease prior to 01/01/1994 or born before 1957*
**2nd dose not required if entered school or in college/university before 07/01/1994*

Mumps
**Not required if entered first grade before 7/1/1987 or entered college/ university prior to 07/01/1994 or born before 1957*
**2nd dose not required if entered school or in college/university before 07/01/2008*

Rubella
**Not required if entered college/university after 30th birthday and before 02/01/1989 or attained 50th birthday*

Titers are accepted, include Date/Result value of each

HPV
** Not required*

POLIO – 4 doses
**Not required if 18 years of age or older*

VARICELLA – 1 dose
**Not required if born before 04/01/2001*
If History of Disease is provided, include Diagnosis Date or Age
Titers are accepted, include Date/Result value

MENINGOCOCCAL (A,C,Y,W) – 2 doses
EDUCATION REQUIRED for all students, Have you received **education only** about the vaccine? *Please write EDUCATION in Section B if you have received education.*
North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Information is available from the CDC website, the Student Health Center website, at the Student Health Center and at orientation.
**Not required if born before 01/01/ 2003*

HEPATITIS A
**Not required*

TB SKIN TEST (PPD or TST)
REQUIRED of *International Students/Non-US Citizens from high risk countries*
Must be administered within the past 12 months
If positive PPD, include date and result of chest x-ray. Attach treatment plan if applicable

PHYSICAL EXAMINATION
A physical examination is *not required* for admission to the University. If a student is taking a physical education course and has a medical condition that may affect participation, the course instructor will request documentation of a physical or will require the student to get a physical prior to participation.

REPORT OF MEDICAL HISTORY

(Please PRINT in black ink) ***To be completed by student***

LAST NAME | FIRST NAME | MIDDLE NAME | UNCW STUDENT ID NUMBER

PERMANENT ADDRESS | CITY | STATE | ZIP CODE | AREA CODE/PHONE NUMBER

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

CLASS YOU ARE ENTERING (circle)
FR SO JR SR GRAD PROF

PREVIOUSLY ENROLLED HERE? ☐ YES ☐ NO
IF YES, DATE(S) ATTENDED_____

SEMESTER ENTERING (circle)
FA SP SUM1 SUM2 OTHER YEAR____

****THIS IS NOT YOUR HEALTH INSURANCE WAIVER**

NAME OF HEALTH INSURANCE COMPANY | AREA CODE/PHONE NUMBER

ADDRESS OF HEALTH INSURANCE COMPANY | POLICY NUMBER / SUBSCRIBER ID NUMBER / SSN

NAME OF POLICY HOLDER | RELATIONSHIP OF POLICY HOLDER TO STUDENT

NAME OF PRIMARY EMERGENCY CONTACT | RELATIONSHIP | AREA CODE/PHONE NUMBER

NAME OF SECONDARY EMERGENCY CONTACT | RELATIONSHIP | AREA CODE/PHONE NUMBER

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 further explanation.

	Yes	No	Year
ADD/ADHD			
Alcohol use			
Allergy injection therapy			
Anemia or Sickle cell anemia			
Anorexia/Bulimia			
Anxiety			
Arthritis			
Asthma			
Back injury			
Bladder infection			
Blood transfusion			
Bone, joint or other deformity			
Broken bone (specify)			
Chronic cough			
Concussion/Severe head injury			
Diabetes			
Disabling depression			
Dizziness or fainting spells			
Drug use			
Easily fatigued			
Excessive worry or anxiety			

	Yes	No	Year
Eye trouble besides glasses			
Frequent or severe headache			
Frequent vomiting			
Gall bladder trouble/gallstones			
Hay fever			
Head/neck radiation treatment			
Hearing loss			
Heart trouble			
Hernia			
High blood pressure			
High cholesterol			
Intestinal trouble			
Irregular periods			
Jaundice or hepatitis			
Kidney infection			
Kidney stone			
Knee problems			
Malaria			
Mononucleosis			
Neck injury			
Pain or pressure in chest			

	Yes	No	Year
Paralysis			
Pilonidal cyst			
Pneumonia			
Protein or blood in urine			
Rectal disease			
Recurrent back pain			
Regular Exercise			
Rheumatic fever			
Serious skin disease			
Sever menstrual cramps			
Sexually transmitted disease			
Shortness of breath			
Sinusitis			
Smoke/smokeless tobacco			
Thyroid trouble			
Tumor or cancer(specify)			
Ulcer (duodenal or stomach)			
Wear bicycle helmet			
Wear seat belt			
Other (specify)			

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

Name_____Use_____Dosage_____

Name_____Use_____Dosage_____

Name_____Use_____Dosage_____

Name_____Use_____Dosage_____

Name_____Use_____Dosage_____

Name_____Use_____Dosage_____

Name_____Use_____Dosage_____

Name_____Use_____Dosage_____

REPORT OF MEDICAL HISTORY-cont'd (Please PRINT in black ink) *To be completed by student*

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?

ADVERSE REACTIONS TO	YES	NO	EXPLANATION
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine			
Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

If you answer YES, fully explain the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

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.

If you answer YES to any question, provide specific details for each response including when, where, and how.

	YES	NO	EXPLANATION
Do you have any conditions or disabilities that limit your physical activities?			
Have you ever been a patient in any type of hospital?			
Has your academic career been interrupted due to physical or emotional problems?			
Is there loss or seriously impaired function of any paired organs)			
Other than for routine check-ups, have you seen a physician or health care professional in the past six months?			
Have you ever had any serious illness or injuries other than those already noted?			

IMPORTANT INFORMATION...PLEASE READ CAREFULLY, SIGN and DATE

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

(A) I have personally supplied and reviewed the above information and attest that it is true and complete to the best of my knowledge. I understand that the information provided is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should become ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (if under 18 son's/daughter's) medical record to a physician, hospital or other medical professional involved in providing me (if under 18 my son/daughter) emergency treatment or medical care.

(B) I hereby authorize any medical treatment for myself (if under 18 son/daughter) that may be advised or recommended by the medical staff of the Student Health Center.

(C) I am aware that the Student Health Center charges for some services and that I (if under 18 son/daughter) may be billed through the university student accounts cashier if the account is not paid at the time of the visit. I (if under 18 son/daughter) accept personal responsibility for settling the account with the cashier and for payment of incurred charges. I am responsible for filing charges with my insurance company and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

Signature of Student _____ Date _____

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

PHYSICAL EXAMINATION (Print in black ink) *To be completed and signed by a healthcare provider*

Last Name First Name Middle Name	Date of Birth {mo/day/year)	UNCW Student ID Number
Permanent Address City State Zip Code		Area Code/Phone Number

Height	Weight	Temperature/Pulse/Respiration / /	Blood Pressure /

IF REQUIRED:
Vision Corrected
Right 20/_____ Left 20/_____
Uncorrected
Right 20/_____ Left 20/_____

Color Vision_____

Hearing (Gross) Right_____ Left_____
15 ft Right_____ Left_____

IF REQUIRED:
Urinalysis Sugar_____ Albumin_____

Micro_____

Hgb or Hct (if indicated)_____

STS (may be required by some departments):
Date_____ Results_____

Recommendations_____

Systems Review	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
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 emotion conditions? 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 Students Admitted to a HEALTH SCIENCES PROGRAM●

Based on my assessment of this student's physical and emotional health on _____/_____/_____ he/she appears to be able to participate in the activities of a health profession in a clinical setting.

YES_____ NO_____

If no, explain _____

Signature_____ Date_____

Printed Name_____

Address _____

Phone# _____ Fax #_____

IMMUNIZATION RECORD

Last Name	First Name	Middle	Date of Birth (MM/DD/YYYY)	Student ID# (850#)

SECTION A REQUIRED IMMUNIZATIONS

All students must submit a combination of 3 DTP, Td or Tdap vaccines regardless of age. One MUST be within the past 10 years.

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
DTaP (Childhood Diptheria, Tetanus, and Pertussis)				
Td booster (Tetanus-diphtheria)				
Tdap booster (Tetanus-diphtheria and pertussis booster)				
Polio (3 doses, only required if 17 years of age or younger)				
MMR (Measles, Mumps, Rubella – 2 MMR vaccines required on or after first birthday OR 2 Measles, 2 Mumps and 1 Rubella single doses OR positive Measles, Mumps, Rubella titers)				
Measles (2 required on or after first birthday OR positive titer OR documented disease date)			**Disease Date	****Titer Date & Result
Mumps (2 required on or after first birthday OR positive titer)			***(Disease Date NOT Accepted)	****Titer Date & Result
Rubella (1 required on or after first birthday OR positive titer)			***(Disease Date NOT Accepted)	****Titer Date & Result
Hepatitis B Series (only required if born after July 1, 1994)				******Titer NOT Accepted for required Hep B Series***

SECTION B RECOMMENDED IMMUNIZATIONS

Received the Meningococcal vaccine (Menactra, Menveo, Menomune, MPSV4, MCV4)? ☐ Yes ☐ No

If **Yes**, date(s) vaccine was received (at least one dose after the age of 16) (MM/DD/YYYY) #1: #2

Immunization Name		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Hepatitis A					
Hepatitis A/B combination series					
Pneumococcal					
Human Papillomavirus (HPV)	Cervarix				
	Gardasil				
Varicella (chicken pox -2 doses, documentation of disease date or positive titer)				**Disease Date	****Titer Date & Result
Tuberculin Skin Test (TST)	Date Read				
	mm induration	mm	mm	mm	mm
	Date of IGRA (QuantiFERON or T-SPOT) test				
	Result of IGRA test	☐Positive ☐Negative	☐Positive ☐Negative	☐Positive ☐Negative	☐Positive ☐Negative

Signature of Health Care Provider **Date**

Printed Name of Health Care Provider **Area Code/Phone Number**

Office Address **City** **State** **Zip Code**