



R.N. ELLINGTON HEALTH AND COUNSELING CENTER

Dear Student:

My staff and I would like to welcome you to Elon University. We hope your experiences will be rewarding, enjoyable and healthy. You should review the following rules and recommendations as they may apply to you.

The enclosed physical examination and immunization form must be completed by your health care provider and mailed to Elon University by July 1 for Fall enrollment, December 15 for January enrollment, January 15 for Spring enrollment, and May 15 for Summer enrollment. The immunization record must be accurately completed as to dates and types of vaccines. North Carolina state laws require that immunizations be completed thirty days following matriculation. After that time, **students will be disenrolled from classes until their immunizations are documented.**

Student's visits to the Health Center are free of charge. There is a nominal fee for lab work, immunizations or medications given. These charges can be paid at the time of service or will be posted to the student's account. Prescriptions from outside physicians may not be filled by the Health Center. When the Health Center staff orders x-rays, emergency treatments, or a referral, any charges incurred are the responsibility of the student. The Health Center clinicians are available to respond to your individual needs during regular clinic hours.

The Health and Counseling Center staff also welcomes phone calls from parents. You can reach the Health Center at (336) 278-7230 and the Counseling Center at (336) 278-7280. Please feel free to drop by any time just to say hello. We look forward to working with you during your time at Elon.

Yours truly,

James Hawkins Jr. M.D. *Katherine E. Parrish* *Bruce F. Nelson, M.S.W., L.C.S.W.*
James Hawkins Jr., M.D. Katherine E. Parrish, F.N.P. Bruce F. Nelson, M.S.W., L.C.S.W.
Medical Director Director of Health Services Director of Counseling Services

**PLEASE RETURN HEALTH FORM TO:
R.N. ELLINGTON HEALTH & COUNSELING CENTER
2040 CAMPUS BOX ELON, NC 27244 FAX: 336.538.6506**

DO NOT SEND YOUR HEALTH FORM TO ADMISSIONS, YOUR COACH OR ATHLETICS

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

GRADUATE STUDENTS

- Records must be documented in black ink and all corrections must be signed.
- The Immunization Record form must be completed. All dates must include **month, day** and **year** of administration.
- Records must include a clinician's signature, health department stamp, or high school record attachment.
- Your immunization records may be obtained from your high school, physician, health department, military record, or previously attended college. These records may not fulfill all requirements as listed below. **It is your responsibility to assure compliance with required immunizations.**
- All Elon University students are required to maintain health insurance either via an employment, parent, or spouse policy or through participation in the student health insurance policy marketed by ABCO 100. Information may be obtained by calling 1-800-222-5780.

IMMUNIZATION REQUIREMENTS PURSUANT TO NC STATE LAW AND INSTITUTIONAL POLICY:

SECTION A.□

Students born in 1957 or later:

- 3 DTP (Diphtheria, Tetanus, Pertussis) or Td (Tetanus, Diphtheria) doses; one Td booster must have been in the last 10 years.
- 3 Polio (oral) doses.
- 2 Measles (Rubeola), 1 Mumps, 1 Rubella (2 MMR doses meet this requirement).
- Tuberculin Skin Test (PPD) and **result** in millimeters within the **twelve months preceding** the beginning of classes (chest x-ray report required if test is positive). Tine test is not acceptable.
- Hepatitis B series-first dose required before matriculation.

Students born before 1957:

- 3 DTP (Diphtheria, Tetanus, Pertussis) or Td (Tetanus, Diphtheria) doses; one Td booster must have been in the last 10 years.
- 1 Rubella dose (MMR meets this requirement) (not required if student is 50 years of age or older.)
- Tuberculin Skin Test (PPD) and **result** in millimeters within the **twelve months preceding** the beginning of classes (chest x-ray report required if test is positive). Tine test is not acceptable.
- Hepatitis B series – first dose required before matriculation.

NOTE.....

- Students who entered college for the first time after 7/1/94 must have two doses of Measles (Rubeola) vaccine after the first birthday (2 MMR doses meet this requirement). History of Measles (Rubeola) is acceptable if physician verifies that the student had the disease prior to January 1, 1994 (except DPT students).
- Positive blood titers are acceptable for Mumps, Measles (Rubeola), Rubella and Hepatitis B. Laboratory test results must be attached.

DPT STUDENTS: ADDITIONAL REQUIREMENTS

- 1.□ Varivax series (2 doses) must be complete or documentation of immunity to chicken pox (Varicella titer with results).
- 2.□ Tuberculin skin test (Mantoux) within one year of enrollment; test must be repeated every 12 months.
- 3.□ Hepatitis B series (3 doses) must be complete.
- 4.□ Students must also have current CPR – American Heart Health Care Provider level certification and must keep current throughout the time they are enrolled in the DPT Education Program.□
- 5.□ DPT program students must present proof of all immunizations or copies of titers during past twelve months. History of disease not acceptable.

REPORT OF MEDICAL HISTORY (please print in black ink) To be completed by student

LAST NAME (print) _____ FIRST NAME _____ MIDDLE NAME _____ SOCIAL SECURITY NUMBER _____

PERMANENT ADDRESS _____ CITY _____ STATE _____ ZIP _____ AREA CODE/PHONE _____
 DATE OF BIRTH (mo./day/year) _____ GENDER M F MARITAL STATUS S M O

CLASS YOU ARE ENTERING (circle): FR. SO. JR. SR. GRAD. DPT	PREVIOUSLY ENROLLED HERE <input type="checkbox"/> YES <input type="checkbox"/> NO PREVIOUSLY A PATIENT HERE <input type="checkbox"/> YES <input type="checkbox"/> NO	SEMESTER ENTERING (circle): fall winter spring sumr. 1 sumr. 2 yr. 20 ____
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HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) TELEPHONE _____

NAME OF POLICY HOLDER _____ SOCIAL SECURITY NUMBER _____ EMPLOYER _____
 IS THIS AN HMO/PPO/MANAGED CARE PLAN? YES NO

POLICY OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY RELATIONSHIP _____

ADDRESS AREA CODE/PHONE _____

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.

FAMILY & PERSONAL HISTORY (please print in black ink) To be completed by student

Has any person, related by blood, had any of the following:

	yes	no	relationship <input type="checkbox"/>		yes	no	relationship <input type="checkbox"/>		yes	no	relationship
High blood pressure				Cholesterol or blood fat disorder				Cancer (type:)			
Stroke				Diabetes				Alcohol/drug problems			
Heart attack before age 55				Glaucoma				Psychiatric illness			
Blood or clotting disorder								Suicide			

Have you ever had or have you 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				Jaundice or hepatitis				Kidney stones			
Rheumatic fever				Allergy injection therapy				Rectal disease				Protein or blood in urine			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Hearing loss			
Pain or pressure in chest				Concussion				Hernia				Sinusitis			
Shortness of Breath				Frequent or severe headache				Easy fatigability				Severe menstrual cramps			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Irregular periods			
Pneumonia				Severe head injury				Eye trouble besides needing glasses				Sexually transmitted disease			
Chronic cough				Paralysis				Bone, Joint or other deformity				Blood transfusion			
Tuberculosis				Epilepsy/Seizures				Shoulder dislocations				Smoke (#Cigarettes a day) ____			
Head or neck radiation				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				Drug use			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Other (specify)			
Diabetes				Pilonidal cyst				Broken bone (specify)				Serious skin disease			
Frequent vomiting				Kidney infection				Mononucleosis				Gall bladder trouble or gallstones			
Bladder infection												Personal Trauma			

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 or nonprescription) you use and indicate how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

FAMILY & PERSONAL HISTORY-CONTINUED (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? 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)			
Have you ever been treated, hospitalized or presently on medication for emotional problems?			
Is there loss or seriously impaired function of any paired organ? (please describe)			
Other than for a routine checkup, have you seen a physician or health-care professional in the past 6 months? (please describe)			
Have you ever had a serious illness or injuries other than those already noted? (specify when and where and give details)			

IMPORTANT INFORMATION...PLEASE READ AND COMPLETE

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

- (A) I have personally supplied (reviewed) the above 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 by Court order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student Health Services to release information from my (son/daughter's) medical record to a physician, hospital, or other medical agency involved in providing me (him/her) with emergency treatment and/or medical care.
- (B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by providers of the Student Health Services.
- (C) I am aware that the Student Health Services charges for some services and I may be billed through the University Bursar if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Bursar and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge my responsibility to the University by the existence of insurance coverage.

Signature of Student _____

Date _____

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

Date _____

IMMUNIZATION RECORD

(please print in black ink)

To be completed and **signed** by physician or clinic

Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	Social Security Number

SECTION A REQUIRED IMMUNIZATIONS

	mo./day/year <input type="checkbox"/>	mo./day/year <input type="checkbox"/>	mo./day/year <input type="checkbox"/>	mo./day/year <input type="checkbox"/>
DTP or Td	(#1) <input type="checkbox"/>	(#2) <input type="checkbox"/>	(#3) <input type="checkbox"/>	(#4) <input type="checkbox"/>
Td Booster				
Polio				
MMR (after first birthday)				
MR (after first birthday)				
Measles (after first birthday)			Disease date	**Titer date & Result
Mumps			(Disease date not applicable)	**Titer date & Result
Rubella			(Disease date not applicable)	**Titer date & Result
Tuberculin (PPD) Test (within 12 months) (Tine Test Not Acceptable) <input type="checkbox"/>	Applied <input type="checkbox"/>	<input type="checkbox"/>	Read <input type="checkbox"/>	Result
Chest x-ray if positive PPD <input type="checkbox"/>	Date <input type="checkbox"/>			
	Results <input type="checkbox"/>			
Treatment, if applicable <input type="checkbox"/>	Date			
Hepatitis B Series				**Titer date & Result

**attach lab report

SECTION B OPTIONAL IMMUNIZATIONS

*Required for Physical Therapy Students <input type="checkbox"/>	mo./day/year <input type="checkbox"/>	mo./day/year <input type="checkbox"/>	mo./day/year <input type="checkbox"/>
Haemophilus influenzae type b <input type="checkbox"/>			
Pneumococcal <input type="checkbox"/>			
Meningococcal <input type="checkbox"/>			
Hepatitis A series <input type="checkbox"/>			
Typhoid (specify type)			
*Varicella (chicken pox) series or documentation <input type="checkbox"/> of immunity (titer date and results)			

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner

Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Date

Office Address and Telephone Number

Do Not Write in This Space

PHYSICAL EXAMINATION(please print in black ink) To be completed and **signed** by physician or clinic

Must be completed by a licensed physician, physician's assistant or nurse practitioner.

Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	Social Security Number

HEIGHT _____ WEIGHT _____ TPR _____ / _____ / _____ BP _____ / _____

Vision: <input type="checkbox"/> Corrected <input type="checkbox"/> Right 20/____ <input type="checkbox"/> Left 20/____ <input type="checkbox"/> Uncorrected <input type="checkbox"/> Right 20/____ <input type="checkbox"/> Left 20/____ <input type="checkbox"/> Color Vision _____ Hearing: (gross) <input type="checkbox"/> Right _____ <input type="checkbox"/> Left _____ <input type="checkbox"/> 15 ft. <input type="checkbox"/> Right _____ <input type="checkbox"/> Left _____ <input type="checkbox"/>	Urinalysis: Sugar _____ Albumin _____ <input type="checkbox"/> Micro _____ Hgb or Hct (if indicated) _____ STS (may be required by some departments) _____ Date _____ Results _____ Recommendations _____
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Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. <input type="checkbox"/> Head, Ears, Nose, Throat			
2. <input type="checkbox"/> Eyes			
3. <input type="checkbox"/> Respiratory			
4. <input type="checkbox"/> Cardiovascular			
5. <input type="checkbox"/> Gastrointestinal			
6. <input type="checkbox"/> Hernia			
7. <input type="checkbox"/> Genitourinary			
8. <input type="checkbox"/> Musculoskeletal			
9. <input type="checkbox"/> Metabolic/Endocrine			
10. <input type="checkbox"/> Neuropsychiatric			
11. <input type="checkbox"/> Skin			
12. <input type="checkbox"/> 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 _____

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

 Signature of Physician/Physician Assistant/Nurse Practitioner Date _____

 Print Name of Physician/Physician Assistant/Nurse Practitioner Date _____