



BELMONT ABBEY COLLEGE

THAT IN ALL THINGS GOD MAY BE GLORIFIED

STUDENT MEDICAL FORM

Deadlines:

August 1 for fall enrollment
January 1 for spring enrollment

Please return this completed form to:

Wellness Center
Belmont Abbey College
100 Belmont – Mt. Holly Road
Belmont, North Carolina 28012
704-461-6877
704-461-6878 Fax
healthservices@bac.edu

This form can be downloaded from:

<http://www.belmontabbeycollege.edu/student-life/wellness-center/medical-forms.aspx>

TO APPLICANT

Please fill in the information regarding personal and family history. Your examining physician should complete the remainder of the information. The information that you provide is confidential. It will be kept in your personal health folder for use by professional staff only. For additional information about completing this health record, please refer to “Guidelines for Completing Student Medical Form.”



WELLNESS CENTER | PHONE: {704} 461 6877 | TOLL FREE: {888} 222 0110 | FAX: {704} 461 6878

BELMONT ABBEY COLLEGE | 100 BELMONT-MT. HOLLY ROAD | BELMONT, NC 28012 | HEALTHSERVICES@BAC.EDU

Guidelines for Completing Student Medical Form

IMPORTANT

- Records must be documented in ink and any corrections must be signed.
- All records must include month, day and year of vaccine administration.
- All immunization documentation needs to have student's name, date of birth, health care provider signature and/or health care facility stamp.

Section A: Required Immunizations

Students 17 years of age

- 3 DTP (Diphtheria, Tetanus, Pertussis) or Td (Tetanus, Diphtheria) doses:
- One Td or Tdap booster must have been administered within the past 10 years*
- 3 Polio (oral) doses
- 2 Measles (Rubeola), 2 Mumps, 1 Rubella (MMR is preferred vaccine)**
- 3 Hepatitis B (If born on or after July 1, 1994)

Students 18 years of age or older

- 3 DTP (Diphtheria, Tetanus, Pertussis) or Td (Tetanus, Diphtheria) doses:
- One Td or Tdap booster must have been administered within the past 10 years.*
- 2 Measles (Rubeola), 2 Mumps, 1 Rubella (MMR is preferred vaccine)**
- 3 Hepatitis B (If born on or after July 1, 1994)

TUBERCULIN SKIN TEST (PPD) is recommended within twelve months preceding the beginning of classes (and chest x-ray if test is positive).

- *If a Td has not been administered in the past 10 years you must receive a Tdap.
- **First MMR must be given after the first birthday. History of Measles (Rubeola) is acceptable if the physician verifies that the student had the disease prior to January 1, 1994.
- Blood titer tests showing immunity are acceptable for Measles, Mumps, Rubella, and Hepatitis B. Laboratory test results must be attached.

Section B: Recommended Vaccines

- Meningococcal
- Varicella (chicken pox) series of two doses or immunity by positive titer

Section C: Other Vaccines

- Hemophilus Influenza type B, Pneumococcal, Hepatitis A series, Influenza, HPV

INTERNATIONAL STUDENTS:

Vaccines are required as noted above. **Records must be in English.**

Report of Medical History:

(Please type or print in black ink.)

REQUIRED

Last Name _____ First Name _____ Middle Name _____
 Permanent Address _____ City _____ State _____ Zip _____ Area code/Phone number _____
 Date of Birth (mo/day/yr) _____ Gender M () F () Marital Status S () M () Other ()

Entering Class: Fr So Jr Sr	Entering Semester: Fall Spring Year
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Insurance Information:

Hospital/Health Insurance (Name and Address of Company) _____ Area code/Telephone Number _____

Name of Policy Holder _____ Social Security Number _____ Date of Birth _____ Employer _____

Policy or Certificate Number (attach copy of card front & back) _____ Group Number _____ HMO/PPO/Managed Care Plan? Yes () No ()

Name of Person to Contact in case of an Emergency _____ Relationship _____ Area Code/Telephone Number _____

Address _____ City _____ State _____ Zip Code _____

THE FOLLOWING HEALTH HISTORY IS CONFIDENTIAL.

Family and Personal History *(Please type or print in black ink.)*

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

	Y	N	Relative		Y	N	Relative		Y	N	Relative
High blood pressure				Cholesterol or blood fat disorder				Alcohol or Drug problems			
Stroke				Diabetes				Psychiatric illness			
Cancer (type _____)				Glaucoma				Suicide			
Heart attack before age 55				Blood or clotting disorder							

Have you ever had (or do you now have) any of the following?

	Y	N	Year		Y	N	Year		Y	N	Year
High blood pressure				Mononucleosis				Pneumonia			
Rheumatic fever				Hay fever				Chronic cough			
Hernia				Thyroid Trouble				Sinusitis			
Pain or pressure in chest				Arthritis				Tuberculosis			
Heart trouble				Concussion				Allergy injection therapy			
Shortness of breath				Anemia				Skin disease			
Asthma				Severe Head Injury				Severe menstrual cramps			
Bladder/Kidney infection				Dizziness or fainting				Irregular periods			
Diabetes				Paralysis				Headaches			
Recurrent back pain				Blood transfusion				Eating/Weight Issues			
Knee problems				Epilepsy/Seizures				Regular Exercise			
Neck injury				Depression/Anxiety				Tobacco Use (Incl. Chew)			
Broken Bones				Kidney Stones				Alcohol Use			
Shoulder dislocation				Sickle Cell Anemia				ADHD/ADD			
Hearing loss				Back injury				Seat Belt Use			
Eye other than glasses				Tumor or cancer							

Please list any medications, vitamins and/or minerals (prescription and non-prescription) you use, and indicate how often you use them.

Name _____ Dosage _____ Name _____ Dosage _____

Name _____ Dosage _____ Name _____ Dosage _____

Family and Personal Health History (continued)

Check each item "Y" or "N". Every "Y" must be fully explained. Use an additional sheet if necessary. Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If "Y", please indicate the type of reaction, your age at the time of reaction and if the reaction has occurred more than once.

	Y	N	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine/other pain reliever			
Other medications, chemicals			
Insect bites			
Food allergies (name)			

	Y	N	Explanation
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 a routine check-up, 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?			

Statement by Student

I have personally supplied the foregoing information and attest that it is true and complete to the best of my knowledge. I hereby give permission to any doctor, hospital, or medical agency to release confidentially to the Belmont Abbey College Health & Wellness Center any information they may have concerning my medical condition and their professional contact with me. I hereby authorize any necessary medical treatment for myself.

Student Signature _____ Date _____

Parent/Guardians of Students Under 18

I hereby authorize any medical treatment for my son/daughter that may be advised or recommended by the physicians or health care professionals of the Belmont Abbey College Health & Wellness Center.

Parent/Guardian Signature _____ Date _____

College Policy for All Students

It is the student's responsibility to keep parents/guardians informed about personal health matters. All reasonable effort will be made to secure the student's permission should the college deem it necessary to communicate with the parents/guardians regarding medical concerns.

North Carolina state law (general Statute 130A-155.1) requires anyone entering college to present a certificate of immunization that documents their compliance with all required immunizations.

Immunization Record: *(Please type or print in black ink.)* **REQUIRED**

Last Name	First Name	Middle Name	Date of birth (mo/day/yr)

Section A: Required Immunizations				
	Mo/day/yr	Mo/day/yr	Mo/day/yr	Mo/day/yr
DTP or Td	#1	#2	#3	#4
Td or Tdap booster within 10 years (circle one)	#5			
Polio				
MMR (2 Doses required)	#1	#2		
Measles	#1	#2	Disease date	Titer Date & Result
Mumps	#1	#2		Titer Date & Result
Rubella	#1			Titer Date & Result
Hepatitis B Series (If born on or after July 1, 1994)	#1	#2	#3	Titer Date & Result

Disease B: Recommended Vaccines

	Mo/day/yr	Mo/day/yr	Mo/day/yr	Mo/day/yr
Meningococcal				
Varicella (chicken pox) series of two doses or immunity by positive blood titer	#1	#2		Titer Date & Result
International Students PPD/BCG	Date	mm induration	Date Chest X-ray	X-ray results
Tuberculin (PPD) Test				
mm indurations				
Chest X-ray (if positive PPD) Date				
Results				
Treatment (if applicable)				

Section C: Other Vaccines

	Mo/day/yr	Mo/day/yr	Mo/day/yr
Hemophilus Influenza, B			
Pneumococcal			
Hepatitis A series			
HPV			
BCG			

Clinician Signature or Clinic Stamp _____ Date _____

Office Address _____

Area code/phone number _____

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Belmont, North Carolina 28012
Phone (704) 461-6877 Fax (704) 461-6878**

Physical Examination: (Please type or print in black ink.)

RECOMMENDED

Your physical examination must be completed by a health care professional

Last Name	First Name	Middle Name	Date of Birth (mo/day/yr)

Permanent Address	City	State	Zip	Area code/Phone number	

Height _____ Weight _____ TPR ____/____/____ BP ____/____

<u>Vision</u>	Corrected	Right: 20/____	Left: 20/____	<u>Urinalysis</u>	Sugar: ____	Albumin: ____
	Uncorrected	Right: 20/____	Left: 20/____		Micro: _____	
	Color Vision: _____			Hgb or Hct (if indicated) _____		
<u>Hearing</u> (gross)	Right: _____	Left: _____				
15 ft.	Right: _____	Left: _____				

Abnormalities	Y	N	Describe
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Mammary			

Is there a loss or seriously impaired function of any paired organs? Yes ____ No ____

Please explain if yes _____

Is the student under treatment for any medical or emotional condition? Yes ____ No ____

Please explain if yes _____

Recommendation for physical activity Unlimited ____ Limited ____

Please explain if limited _____

Is the student physically and emotionally healthy? Yes ____ No ____

Please explain if no _____

Signature of Physician, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant

Date

Print name and title of health care professional, include office address and phone number with area code