MEREDITH COLLEGE

Raleigh, North Carolina

Upon completion of pages 12-15 return all pages together to:

Meredith College
Office of Admissions
3800 Hillsborough Street
Raleigh, NC 27607-5298

STUDENT MEDICAL FORM (pages 11-15)

Instructions for Completing Medical Form

NOTE: The deadline for submssion of the Student Medical Form is JUNE 1. In accordance with N.C. law, students will be withdrawn from the College 30 days after classes begin if immunization requirements have not been met and the Student Medical Form has not been returned to the Office of Admissions. Please submit pages 11-15 together after all forms are complete.

READ CAREFULLY

1. **Complete pages 12 -15 of the form. Page 15 should be completed by your healthcare provider.**
   - Records must be documented in black ink and all corrections must be signed.
   - All immunization dates must include month, day and year of administration.

2. **Ask your physician or your county health department to bring your immunizations and tuberculin skin test up to date if necessary. Please refer to www.immunize.nc.gov/schools for more information regarding state requirements. Keep in mind that:**
   - All **required** immunizations listed are mandatory for enrolling at Meredith;
   - A **tuberculin skin test** within 1 year prior to your enrollment at Meredith is also required. Please have your tuberculin skin test read before submitting this form.
   - Immunizations that are required pursuant to NC state law:
     - All students: Three doses of Tetanus/Diphtheria toxoid; one of which must be Tetanus/Diphtheria/Pertussis.
     - Students born in 1957 or later: 2 Measles (Rubeola), 2 Mumps, 1 Rubella.
     - Students born before 1957: 2 Measles (Rubeola) and 2 Mumps or proof of immunity by titer with lab report. Rubella is NOT required for students 50 years of age or older.
     - Students under the age of 18: Polio series.
     - Students born after 7/1/1994: 3 Hepatitis B doses.
     - Effective for the 2021-22 academic year, two doses of meningococcal conjugate vaccines are required.
     - If immunizations are unavailable, you may submit a titer for proof of immunity, attach with the lab report.
   - Immunizations records can be obtained from:
     - Your pediatrician's or family physician's office
     - Your high school transcript
     - The local department of health
     - Records from previous college/university
     - For more information on how to obtain vaccine records please visit: CDC: http://www.cdc.gov/vaccines/recs/immuniz-records.htm

3. **Ask your physician to review the information you provided and to complete and sign the remainder of the form. Make sure that she/he:**
   - Reviews the immunization history and updates all necessary immunizations.
   - Signs the applicable section of page 14 certifying that your medical history, immunizations, TB skin test, and physical examination are complete.
   - Students who plan to play intercollegiate sports must have their physical dated after **APRIL 30**.

4. **Complete pages 12-15 of this form. Page 15 must be completed or you may request and forward copies of your physical exam, immunizations, and tuberculin skin test from the former institution (updates may be required). Meredith requires health insurance as a condiiton of enrollment if opting out of the Meredith sponsored plan.**

5. **Meredith requires health insurance as a condiiton of enrollment. All full-time undergraduate students must complete the insurance waiver online if securing their own insurance and opting out of the Meredith sponsored plan.**

6. **Check your medical form for completion, sign page 14 and mail all pages together to the address above by JUNE 1.**
   Questions regarding this form should be directed to Health Services at (919) 760-8535, or healthcenter@meredith.edu.

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IMPORTANT: Pages 11-14 must be completed, returned to the College and found complete by Health Services before you can register for classes. Information supplied will be used as an aid in providing necessary care while you are a student. The information is strictly for the use of Health Services and will not be released to anyone without your knowledge and written consent.

STUDENT MEDICAL FORM (CONTINUED)

Report of Medical History

Last Name (print) First Name Middle Name Last four digits of Social Security Number

Permanent Address City State ZIP

Area Code/Telephone Date of Birth (mo/day/yr) Age

Cell phone (student) Student's email (please print)

Marital Status: ◯ S ◯ M ◯ Other

Class You are Entering: ◯ FR ◯ SO ◯ JR ◯ SR

Previously Enrolled Here: ◯ Yes ◯ No

Semester Entering: ◯ Fall ◯ Spring Year 20____

Hospital/Health Insurance (Name and Address of Company) Subscriber/Policy Number

Name of Policy Holder Employer

Name of Person to Contact in Case of an Emergency Relationship

Address (Home) Area Code/Telephone (Work) Area Code/Telephone

(Cell) Area Code/Telephone Emergency Contact Email

Family & Personal Health History

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 more explanation.

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

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol or blood fat disorder				Blood or clotting disorder			
Stroke				Diabetes				Alcohol/drug problems			
Cancer (type:)				Glaucoma				Psychiatric illness			
Heart attack before age 55								Suicide			

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STUDENT MEDICAL FORM (CONTINUED)

Family & Personal Health History continued

Have you ever had or do you have 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				Protein or blood in urine			
Rheumatic fever				Head or neck radiation treatments				Rectal disease				Hearing loss			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Sinusitis			
Pain or pressure in chest				Concussion				Hernia				Severe menstrual cramps			
Shortness of breath				Frequent or severe headache				Easy fatigability				Irregular periods			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Blood transfusion			
Pneumonia				Severe head injury				Eye trouble besides need for glasses				Smoke 1+ pack cigarettes/week			
Chronic cough				Paralysis				Bone, joint or other deformity				Diabetes			
Tuberculosis				Epilepsy/Seizures				Back injury				Anorexia/Bulimia			
Tumor or Cancer (specify)				Disabling depression				Broken bones				Allergy injection therapy			
Malaria				Excessive worry/anxiety				Kidney infection				Chickenpox (Disease)			
Thyroid trouble				Frequent vomiting				Bladder infection							
Serious skin disease				Gall bladder trouble or gallstones				Kidney stone							
Alcohol/drug abuse Sexually transmitted disease Mononucleosis				Ulcer (duodenal or stomach) Intestinal trouble Pilonidal cyst Self-induced vomiting				Shoulder dislocation Knee problems Recurrent back pain Neck injury							

Student Name _____
Last Name First Name Middle Name

Please describe any conditions or disabilities that would exclude participation in physical activities: _____

Please list all medications including those used for contraception, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

Brand Name Use Dosage

Brand Name Use Dosage

Brand Name Use Dosage

Brand Name Use Dosage

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STUDENT MEDICAL FORM (CONTINUED)

Report of Health Evaluation

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.

Adverse Reaction to:			
Penicillin	Yes	No	Please explain
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

Have you tested positive for COVID in the past six months?	Yes	No	Please explain
Have you had a COVID vaccine?			
Have you ever been a patient in any type of hospital? (Specify when, where and why.)			
Has your academic career been interrupted because of physical or emotional problems? (Please explain.)			
Is there loss or seriously impaired function of any paired organs? (Please describe.)			
Other than for a routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe.)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when, where and give details.)			

Important Information — Please read and complete

STATEMENT BY STUDENT: I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I hereby authorize medical treatment which may be advised or recommended by the medical personnel of the Student Health Services of Meredith College. If serious illness of any kind requires hospitalization, emergency treatment or major surgery, I understand that my parents or guardian will be contacted by telephone if at all possible. If they cannot be reached, emergency treatment may be given as necessary for my well-being.

Signature of Student Date Signature of Parent or Guardian *(if under 18 years of age)*

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STUDENT MEDICAL FORM ✓*Checklist*

- ◯ Ensure all required immunizations are listed (according to NC State law)
- ◯ Make sure the physician completes and signs the physical exam form, page 15
- ◯ Make sure your Tuberculin (PPD) test is current (within 12 months)
- ◯ Complete the insurance waiver process online. See page 16
- ◯ Make a copy of pages 12-15 for your records

STUDENT MEDICAL FORM (CONTINUED)

Report of Health Evaluation

Last Name **First Name** **MI** **Date of Birth**

Immunizations—ALL students must complete *(*If Titers are necessary, please attach lab report)*

Vaccine	Series Date	Series Date	Series Date	*Titer Date
DTP (Date of series required)	#1	#2	#3	
Tdap **(Booster within ten years required)**				
Polio (required if under 18 years of age)	#1	#2	#3	
Hepatitis B (required if born after 7/1/94)	#1	#2	#3	
Measles (Rubeola) on or after 1st birthday	#1	**Booster required: #2**		
Mumps	#1	**Booster required: #2**		
Rubella (German measles)	#1			
Meningococcal (required) See page 11	#1	#2		
Gardasil - HPV (recommended)	#1	#2	#3	
Varicella/Chicken Pox (recommended)	#1	#2		

Tuberculin (PPD) Test **(required within 12 months)**	Date given Date read	**Required Results**	**mm induration**
Chest x-ray, if positive PPD	Date		**Results - Attach copy of the report**
Treatment, if applicable	Date		

The North Carolina Immunization Law *requires that students entering college present to the school authorities immunization certification.*

Please note that if this requirement is not met, dismissal from school 30 days after registration is mandatory under the law.

Please Do Your Part

to make sure you have the minimum immunizations required before sending in your form. Refer to www.immunize.nc.gov/schools.

X _____ ____ / ____ / ____

Signed by Physician or Health Department Stamp (Mandatory) Date

Physical Examination (All students under age 23, including transfers):

TO THE EXAMINING PHYSICIAN:Please review the student's medical history, immunization history, proof of PPD, and then complete the examination and general comments portion of this form.

Height	Weight	BP	Pulse	Temp.
Vision R 20/	L 20/	Corrected	Hearing (Gross) R	L

Are there abnormalities of the following systems?

System	Yes	No	System	Yes	No
1. Head, Ears, Nose, Throat			9. Musculoskeletal		
2. Eyes—Fundi			10. Metabolic/Endocrine		
3. Respiratory			11. Neurological		
4. Lymphatic			12. Skin		
5. Cardiovascular			13. Psychiatric		
6. Gastrointestinal			Describe fully.		
7. Hernia					
8. Genitourinary					

General Comments (diagnosis, recommendation, etc.)

Physical Activity? ◯ Unlimited ◯ Limited

Explain: _____

Is this student now under treatment for any medical and/or emotional condition? ◯ Yes ◯ No

Explain: _____

Print Name of Physician, Physician Assistant or Nurse Practitioner Date Signature of Physician, PA or NP

Office address Area Code/Office Telephone

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