Pfeiffer UNIVERSITY
Beyond Boundaries

Student Medical Forms

Instructions for Completing Medical Forms

DEADLINE FOR COMPLETED MEDICAL FORMS

JULY 15-Fall Enrollment **December 15-Spring Enrollment**

Failure to submit forms can result in not being able to attend class and participate in any University activities.

1. **MANDATORY requirements for all new students (Freshman, Transfers and International)**

   - ☐ Medical History (completed by student)
   - ☐ Immunizations * Required pursuant to North Carolina State Law*
     - 3 DTP (Diphtheria, Tetanus, and Pertussis) and Tdap Booster must have within the last 10 years.
     - 2 MMR (Measles, Mumps, Rubella)
     - 3 Polio (only required if 17 years of age or younger)
     - Hepatitis B Series (only required if born after 7/1994)
     - Tuberculosis (TB) required if…
       - You are an international student from a high risk country
       - You are a non-U.S. citizen from a high risk country
       - You have traveled to a high risk country for more than one week within the last 12 months.

2. **Ensure all forms include dates (mm/dd/yy) and required signature(s).**

3. **Students who plan to play intercollegiate sports** must complete this packet in addition to the required medical information requested by the Athletic Department.

4. **Submit all completed forms and return to the address listed below.**

Additional information can be found in My.Pfeiffer using the credentials provided by Office of Admissions.

Return Completed Forms to:
Pfeiffer University
Attn: Health Services
P.O. Box 960
Misenheimer, NC 28109

Fax: 704-463-1361

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

Last Name First Name Middle Name Student ID Cell phone

Permanent Street Address City State Zip Code Telephone

Date of Birth (mm/dd/yy) _____ Gender: (circle) M F Marital Status: (circle) S M O

Entering Class Status (circle)
FR SO JR SR GRAD
Entrance Year: ___

Previously enrolled here (circle): Yes No
Previously a patient here (circle): Yes No

Semester entering (circle):
Fall Spring Summer

Name of Emergency Contact person Relationship to you

Address Telephone

The following health history is confidential and does not affect your admission status. Please attach additional sheets for items that require fuller explanation.

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

			Relationship
High blood pressure	Y	N	
Stroke	Y	N	
Heart attack before age 55	Y	N	
Blood or clotting disorder	Y	N	
Cholesterol or triglycerides	Y	N	
Diabetes	Y	N	

			Relationship
Glaucoma	Y	N	
Cancer--type?	Y	N	
Alcohol/drug problems	Y	N	
Psychiatric illness	Y	N	
Suicide	Y	N	

Please check any problem the student has or had:

Acne	Deep vein thrombosis	Hepatitis	+PPD
ADD, ADHD, LD	Depression	Herpes Simplex Virus (HSV), genital	Rhinitis, allergic
Allergy Injection Therapy	Diabetes Type I (insulin)	Human Papilloma Virus (HPV), genital	SBE prophylaxis
Amenorrhea	Diabetes Type II (non-insulin)	Hypercholesterolemia	Sickle cell disease/trait
Anemia	Dysfunctional uterine bleeding	Hypertension	Sinusitis, chronic
Anxiety	Dysmenorrhea	Irritable Bowel Syndrome (IBS)	Substance abuse -- alcohol
Asthma	Eating disorder	Mitral valve prolapse	Substance abuse -- drugs
Abnormal Pap smear	Eczema	Mobility impaired	Thyroid disease
Back pain -- chronic	Endometriosis	Obsessive compulsive disorder (OCD)	Thrombophlebitis
Bleeding disorder	Epilepsy/seizure disorder	Ovarian cyst	Tobacco use
Breast Problem	Gallbladder disease	Pelvic inflammatory disease (PID)	Ulcerative colitis
Cancer--type?	Gastritis	Peptic ulcer disease	Uterine fibroids
Cardiac arrhythmia	Gastroesophageal reflux	Polycystic ovary disease	Other
Concussion	Headaches--chronic	Premenstrual syndrome	
Crohn's Disease	Hearing impaired	Pulmonary embolism	
Cystitis--recurrent	Heart murmur	Pyelonephritis	

☐ I would like someone from Counseling Services to contact me about mental health resources on campus.

Please describe any conditions or disabilities that would exclude participation in physical education. _____ _____

Do you exercise three or more times per week? ☐ No ☐ Yes _____

Do you use a seatbelt on a regular basis? ☐ No ☐ Yes _____

FAMILY & PERSONAL HISTORY (continued) **To be completed by student.**

Last Name First Name Middle Name Date of Birth (month/day/year)

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 it occurred and if the experience has occurred more than once.

ALLERGIC REACTIONS	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

Please answer the following questions. If yes, please provide requested details in the explanation.

MEDICAL CARE HISTORY	Yes	No	Explanation
Have you ever been a patient in any type of hospital? If yes, specify when, where and why.			
Have you ever been treated, hospitalized or are you presently on medication for emotional problems?			
Other than for a routine checkup, have you seen a physician or health-care professional in the past 6 months? If so, please describe.			
Have you ever had a serious illness or injuries other than those already noted? If so, specify when and where and give details.			

IMPORTANT INFORMATION -- PLEASE READ AND COMPLETE

STATEMENT BY STUDENT/PARENT/LEGAL GUARDIAN: I am aware that Health Services charge for some services and I will be billed through the Financial Services Office. I accept personal responsibility for settling the account with the cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the University is unaffected by the existence of insurance coverage.

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 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 and unable to sign the appropriate forms, I hereby give my permission for Health Services to release information from my medical record to a physician, hospital or other medical agency involved in providing me with emergency treatment and/or medical care.

Signature of Student Date

PARENT/LEGAL GUARDIAN OF STUDENT UNDER 18: I hereby authorize any medical treatment for my son/daughter which may be advised or recommended by the physicians of Health Services.

Signature of Parent/Legal Guardian if 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 (month/day/year)

REQUIRED IMMUNIZATIONS		***Completion of required immunizations, including MMR, is mandatory.***		
	Date	Date	Date	Date
DTP	#1	#2	#3	#4
Td or Tdap (1 in last 10 years)				
Polio				
Hepatitis B Series				

MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION/IMMUNITY -- Provide documentation of two (2) MMR vaccines or dates of positive titers confirming immunity. NOTE: First vaccine must be given after 12 months of age.
Second vaccine must be given at least one month after the first.
A history of having the measles, mumps or rubella disease is not acceptable proof of immunity.

	Date	Date	
MMR -- Vaccine	#1	#2	***OR***
Positive Titers			Date
	Measles(Rubella)		
	Mumps		
	Rubella		

RECOMMENDED IMMUNIZATIONS				
	Date	Date	Date	
Hepatitis A Series				
Meningococcal				***(advised for on-campus residents)***
Varicella (chicken pox) Series OR				
Varicella Titer				

TUBERCULOSIS (TB) SCREENING TEST -- ***Required only of persons at high risk for TB*** as defined by the Centers for Disease Control (foreign-born persons from high prevalence countries, persons with compromised immune systems, close contacts of infectious TB cases). PPD (Mantoux) must have been administered within the past 6 months only to persons at high risk.
Individuals with a past positive PPD result are required to document the date and mm induration of the past positive PPD and have a chest x-ray within the past 6 months.

Positive PPD Date: _____ Result: _____ Must include mm induration. (negative is not acceptable)
If results >/= to 10 mm induration, the following is **REQUIRED**:
Chest x-ray after the date of the PPD:

Attach copy of x-ray report

OR
Documentation of INH Therapy: Date Began: _____ Date completed: ____

Signature or Clinic Stamp required.

Signature of Physician/Physician Assistant/Nurse Practitioner Date

Print Name of Physician/Physician Assistant/Nurse Practitioner Date

Office Address Office Telephone