UNC GREENSBORO
Division *of* Student Affairs
Student Health Services

IMMUNIZATION OFFICE
336.334.5340 Phone
336.334.5357 Fax
immunize@uncg.edu

Welcome to the University of North Carolina at Greensboro.

The Student Medical Form is designed to collect information about your health history and current immunization status. Please complete and return this form **BEFORE** you arrive on campus. You should make and keep a copy of your Student Medical Form for future reference.

Do I need to complete the attached Student Medical Form?

YES. All enrolled students are required to complete the UNCG Student Medical Form. A physical examination is not required for UNCG students. If you have any questions, please consult Student Health Services at 336-334-5340.

Do I need to complete the immunization record?

YES. All students must complete the immunization record and mail it to Student Health Services prior to Spring or Fall enrollment unless you are exempt.

Students are exempt from immunizations if they do not live on campus and take any combination of the following:

1. Off-campus courses
2. Evening courses
3. Weekend courses
4. No more than four traditional day credit hours in on-campus courses

The Immunization Clinic, located in the Anna M. Gove Student Health Center, is open year round to administer needed immunizations at a nominal fee.

We hope your experience at UNCG is a healthy one!

NOTE: Immunization requirements are mandatory under state law (North Carolina General Statute 130a 152-157). If immunization requirements are not met, registration for classes will be cancelled. Registration will not be reinstated until immunization requirements are met.

University of North Carolina at Greensboro
Student Health Services

Attn: Immunizations Office
Greensboro, NC 27402-6170

Office: 336-334-4086
Fax: 336-334-5357

Meningococcal (Meningitis) Disease and Vaccination Information Sheet

Meningococcal Disease is a rare but potentially fatal bacterial infection caused most often by the bacterium Neisseria meningitides. Meningococcal Meningitis is an inflammation of the membranes surrounding the brain and spinal cord that can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death. Meningococcal bacteria are transmitted through the air via droplets of respiratory secretion, by oral contact with shared items, such as cigarettes or drinking glasses, by kissing, or by direct contact with an infected person. Although anyone can come in contact with the bacteria that cause meningococcal disease, data also indicate certain social behaviors, such as exposure to passive and active smoking, bar patronage, and excessive alcohol consumption, may put students at increased risk for the disease. Patients with respiratory infections, compromised immunity, those in close contact to a known case, and travelers to endemic areas of the world are also at increased risk.

Symptoms usually associated with meningococcal disease include fever, severe headache, stiff neck, rash, nausea, vomiting, and lethargy, and may resemble the flu. Meningitis usually peaks in late winter and early spring and its flu-like symptoms make diagnosis difficult. The bacteria may be carried in the nose or throat without symptoms. Meningococcal may also cause other body infections instead of meningitis, such as septic arthritis, brain inflammation, and pneumonia. Because the disease progresses rapidly, often in as little as 12 hours, students are urged to seek medical care immediately if they experience two or more of these symptoms concurrently.

Vaccination is available to protect against four of the five most common strains of bacteria that cause meningitis in the United States--types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students: The current vaccine does not protect against the group B bacteria strain. The meningococcal vaccine (MCV4) that covers A, C, Y and W may not protect against the group B bacteria strain. An additional vaccination for meningitis B is available and recommended.

The Centers of Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommends that college students, particularly freshman living in the residence halls, be educated about meningitis and the benefits of vaccination. The recommendation is based on recent studies showing that college students living in the residence halls, particularly freshmen, have six-fold increased risk of contracting meningitis over other college students. The recommendation further states that information about the disease and vaccination is appropriate for other undergraduate students who also wish to reduce their risk for the disease. To learn more about meningitis and the vaccine, I encourage you to visit the CDC website at **https://www.cdc.gov/meningitis/bacterial.html,** consult your health care provider, or you may contact our Immunization Office at 336.334.4086.

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Student Medical Form

Please print in black ink. To be completed by student.

Last Name	First Name	Middle Name	Date of Birth	Student ID#

Permanent Address | City | State | Zip Code | Phone Number

Email Address

Gender: Male ☐ Female ☐ **Marital Status:** S ☐ M ☐ Other ☐

Class you are entering (circle):	**Previously Enrolled Here? (circle):**	**Semester Entering (circle):** Fall Spring
Fr. So. Jr. Sr. Grad. N/A	Yes No	Summer 1 Summer 2 Other Year 20___

Name of Person to Contact in Case of Emergency | Relationship

Address | City | State | Zip 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.*

Family & Personal Health 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
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			
Alcohol/Drug Problems			

	Yes	No	Relationship
Cancer			
Type:			
Psychiatric illness			
Suicide			

Have you ever had or have you now? (Please check the appropriate column to the right of each item and, if yes, indicate the year of first occurrence.)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer			
Specify:			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer			
Specify: (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gallbladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or sickle cell anemia			
Eye trouble besides corrective lenses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone			
Specify:			
Kidney infection			
Bladder infection			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted disease			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/bulimia			
Smoke 1+ pack cigarette/week			
Regularly exercise			
Wear seat belt			
Other (Specify):			
Other (Specify):			

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and 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 _____

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Please list and specify any adnverse reactions to medications (hypersensitivities, upset stomach, rash, hives, etc.) and/or allergies (food, insect bites, chemicals, etc.) youhave ever experienced.

Adverse Reactions to:			Explanation

Check each item "yes" or "no" and explain all "yes" answers.

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for a routine checkup, have you seen a physician or healthcare professional in the past six months? (Please describe)			
Have you ever had any 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 is Under Age 18 or under guardianship)

(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 otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical profession 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 the physicians of the Student Health Service.
(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. 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.

Signature of Student _____ Date _____

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