# St. Andrews Presbyterian College Student Health & Wellness Center

## *Health Information Summary*

## Students and Parents

- Students may not move on campus or register for classes until cleared by Health Services.
- Please type or print with ink.
- Please mail the completed form directly to:
  **Health and Wellness Services**
  **St. Andrews Presbyterian College**
  **1700 Dogwood Mile**
  **Laurinburg, NC 28352**
- *Questions?* **Phone (910) 277-5040**.

***Notice:* Do Not Mail Until Form is Complete.**
***Must Be Returned by Aug. 1***

Student's Full Name ______________________________ Phone (C)__________
Last First Middle

Home Address ______________________________ Phone (H)__________
Street City/State Zip Code

Date of Birth_____/_____/_____ Marital Status_______ Sex ______ Age _____ Social Security No.__________

Date entering SAPC__________ Undergraduate: ❑ Freshman ❑ Sophomore ❑ Junior ❑ Senior

Name of Next of Kin __________ Relationship__________ Phone (H) __________

Address of Next of Kin ______________________________
Street City/State Zip Code

Business Address of Next of Kin ______________________________ Phone (O) __________
Street City/State Zip Code Phone (C) __________

Name of Other Emergency Contact __________ Relationship __________ Phone (H) __________

Emergency Contact Address______________________________ Phone (O) __________
Street City/State Zip Code Phone (C) __________

USA Citizen? ❑ Yes ❑ No If no, what is your nationality?__________

## Authorization and Consent

(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 Service to release information from my (son's/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 the physicians of the Student Health Services. I understand that I am responsible for all medical costs incurred.

Signature of Student ______________________________ Date __________

Signature of Parent/Guardian
*(if student is under age 18)*______________________________ Date__________

## Health Insurance Information Required. Please Submit Both Sides of Insurance ID Card.

Name of Insurance Company__________ Subscriber ID# __________ Group # __________

Address of Insurance Company__________ Subscriber's Name __________

Is **PREADMISSION CERTIFICATION** required by your insurance carrier? ❑ Yes ❑ No If yes, provide Phone #__________

**Student's Full Name** ______________________________________________

Last First Middle Nickname

# Medical History

Please complete this section before going to your physician for examination. You have been accepted. The information supplied will not affect your admission status; it will be utilized for health care purposes only.

### Family History - Please Answer All Questions

| Family History | Age | State of Health | Occupation | Age of Death | Cause of Death |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| | | | | | |
| | | | | | |
| Sisters | | | | | |
| | | | | | |
| | | | | | |

| Have any of your relatives ever had any of the following? | Yes | No | Relationship |
|---|---|---|---|
| Alcohol or Drug Abuse | | | |
| Arthritis | | | |
| Asthma | | | |
| Blood or clotting disorder | | | |
| Cancer | | | |
| Depression/Anxiety | | | |
| Diabetes | | | |
| Epilepsy or seizures | | | |
| Heart disease | | | |
| High blood pressure | | | |
| Kidney disease | | | |
| Migraine headaches | | | |
| Nervous or mental disease | | | |
| Suicide attempt | | | |
| Tuberculosis | | | |
| Ulcer or intestinal disease | | | |

**Remarks or Additional Information:**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

### Personal History: Please Answer All Questions

*Comment on all positive answers under remarks*

| Have you ever had any of the following? | Yes | No | Year |
|---|---|---|---|
| Scarlet Fever | | | |
| Measles | | | |
| German Measles | | | |
| Mumps | | | |
| Chicken Pox | | | |
| Malaria | | | |
| Infectious Mono. | | | |
| Gum or tooth trouble | | | |
| Sinusitis | | | |
| Eye trouble | | | |
| Ear, nose, throat trouble | | | |
| Surgery | | | |
| Appendectomy | | | |
| Tonsillectomy | | | |
| Hernia repair | | | |
| Other (specific) | | | |
| Alcohol or substance abuse problem | | | |

| Have you ever had any of the following? | Yes | No | Year |
|---|---|---|---|
| Pain/pressure in chest | | | |
| Bronchitis | | | |
| Palpitations (heart) | | | |
| High or low blood pressure (circle) | | | |
| Rheumatic Fever | | | |
| Heart Murmur | | | |
| Arthritis | | | |
| Injury to joints | | | |
| "Trick" knee, shoulder | | | |
| Back problems | | | |
| Tumor, Cancer | | | |
| Jaundice - Hepatitis | | | |
| Stomach/Intestinal trouble | | | |
| Insomnia | | | |
| Anemia | | | |

| Have you ever had any of the following? | Yes | No | Year |
|---|---|---|---|
| Frequent anxiety | | | |
| Frequent depression | | | |
| Worry or nervousness | | | |
| Recurrent headaches | | | |
| Recurrent colds | | | |
| Head injury with unconsciousness | | | |
| Hay Fever | | | |
| Asthma | | | |
| Tuberculosis | | | |
| Shortness of breath | | | |

| Have you ever had any of the following? | Yes | No | Year |
|---|---|---|---|
| Gallbladder disease | | | |
| Diabetes | | | |
| Recurrent diarrhea | | | |
| Rupture, hernia | | | |
| Kidney/bladder disease or infection | | | |
| Dizziness, fainting | | | |
| Weakness/paralysis | | | |
| Albumin (sugar in urine) | | | |
| Convulsions/seizures | | | |
| Eating disorders | | | |
| | | | |
| **FEMALES ONLY** | | | |
| Irregular periods | | | |
| Severe cramps | | | |
| Excessive flow | | | |
| Average days/period: | | | |

# Statement By Student

I have personally supplied all of the above information and attest that it is true and complete to the best of my knowledge.

______________________________________________

**Signature of Student**

______________________________

**Date**

## Medical History Continued

Check each item **Yes** or **No**. Every item checked Yes must be fully explained in the space on the right (or on an additional sheet of paper).
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.

| Have you ever had adverse reactions to any of the following: | Yes | No | Explanation/Year? |
|---|---|---|---|
| Penicillin | | | |
| Sulfa | | | |
| Other antibiotics (please specify) | | | |
| Aspirin | | | |
| Codeine or other pain relievers | | | |
| Other drugs, medicines, chemicals (please specify) | | | |
| Insect bites/stings | | | |
| Food allergies (please specify) | | | |

| | Yes | No | Explanation/Year? |
|---|---|---|---|
| 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? If Yes, please specify when, where and why. | | | |
| Has your academic career been interrupted due to physical or emotional problems? If Yes, please explain. | | | |
| Is there loss or seriously impaired function of any paired organs? If Yes, please explain. | | | |
| Other than a routine check-up, have you seen a physician or health care professional in the past six months? If Yes, please explain. | | | |
| Have you ever had any serious illness or injuries other than those already noted? If Yes, give details, specifying when and where. | | | |

**Student's Full Name** ______________________________________________
Last First Middle Nickname

**Social Security Number**______________________ **Date of Birth:**___________________

## Report of Health Evaluation - Physician's Form

**To the Examining Physician:** Please review the student's history and complete the physician's form. Please comment on all positive answers. **This student has been accepted.** The information supplied will not affect his/her status; it will be used only as a background for providing health care. This information is strictly for the use of Student Health Services and will not be released without student consent.

Thank you for your cooperation in completing this form.

Uncorrected Vision: Right 20/_____ Left 20/_____
Corrected Vision: Right 20/_____ Left 20/_____
Height: _______ inches
Weight: _______ pounds
Blood pressure: _______/______
Pulse: _____________

**Are there any abnormalities of the following systems?**
**Please attach a full description.**

| Systems | Yes | No |
|---|---|---|
| Head, Ears, Nose or Throat | | |
| Respiratory | | |
| Cardiovascular | | |
| Gastrointestinal | | |
| Hernia | | |
| Eyes | | |
| Genitourinary | | |
| Musculoskeletal | | |
| Metabolic/Endocrine | | |
| Neuropsychiatric | | |
| Skin | | |
| Is there loss or seriously impaired function of any organ? | | |

**List any drugs, medicines, birth control pills and vitamins (prescription and non-prescription) used, frequency of use and dosage.**

| Name of drug/vitamin | Frequency of Use | Dosage |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Required Procedures

**Urinalysis:**
Date _________________
Sugar_________________
Albumin_______________
Micro._________________

**Hemoglobin or Hematocrit:**
________________________

**Recommendations for physical activity (PE, Intramurals, etc.):**
❑ Limited ❑ Unlimited Explain below:

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

**Do you have any recommendations regarding the care of this student?**
❑ Yes ❑ No Please attach supporting documentation.

**Is this student now under treatment for any medical or emotional condition?**
❑ Yes ❑ No Please attach supporting documentation.

**Does Student Health Services need to participate in treatment of any kind?**
❑ Yes ❑ No Please attach supporting documentation.

**Have you any general comments?** ❑ Yes ❑ No

______________________________________________
______________________________________________

**Does this student have a condition requiring special housing considerations?**
❑ Yes ❑ No Please attach supporting documentation.

**Is this student physically cleared to participate in NCAA athletics?**
❑ Yes ❑ No ❑ N/A

**Is this student physically cleared for participation in the equestrian program?**
❑ Yes ❑ No ❑ N/A

Signature of Physician________________________________________

Print Name Here______________________________________________

Address____________________________________________________

Business Phone ___________________________ Date ________________

**Please Notify St. Andrews Presbyterian College Student Health Services of ANY Medical Problems Which Develop After This Examination.**

# St. Andrews Presbyterian College Student Health & Wellness Center
## *Student Health Services Immunization Record*

**To be completed by Physician.**

Student's Full Name ______________________________________________
Last First Middle Nickname

Home Address ______________________________________ Phone (H)______________
Street City/State Zip Code

**North Carolina State Law required vaccinations are as follows: MMR, Tetanus-Diphtheria, and Tuberculosis. These vaccinations must be completed prior to arriving on campus. If a student does not receive required immunizations prior to campus registration, additional charges may occur.**

**To Be Completed and Signed by Your Healthcare Provider.** All information must be in English.

**1. M.M.R. (Measles, Mumps, Rubella) (two doses required.)**

A. Dose 1 given at age 12-15 months or later ……………………………………………….#1________/_______
M Y

B. Dose 2 given at age 4-6 years or later, and at least one month after first dose ………………..#2_______/________
M Y

**2. Tetanus-Diphtheria (Primary series with DtaP or DTP and booster.)**

A. Primary series with four doses with DtaP or DTP: If your last DtaP or DTP was over 10 years ago you must have a Td booster.
#1____/____ #2____/____ #3____/____ #4____/____
M Y M Y M Y M Y

B Tetanus-Diphtheria (Td) _____/_____ **Must be within the last 10 years.**
M Y

**3. Tuberculosis Screening**

A. Tuberculin Skin Test: **Must be within the last year.**

Date given: _____/_____/_____ Date read: _____/_____/_____
M D Y M D Y

Result: ____________ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive _____ negative _____

B. Chest x-ray (required if tuberculin skin test is positive) result: positive _____ abnormal _____

Date of the chest x-ray:_____/_____/_____
M D Y

**Health Care Provider**

Printed Name ______________________________Address______________________________

Signature ______________________________Phone (          ) ______________________

**This form is for additional immunization(s) the student may have received. They are not required for college entry per North Carolina state law. Health and Wellness does not provide hepatitis B or meningococcal vaccinations. We strongly recommend students receive them. These must be given by your health care provider.**

1. Hepatitis B (three doses of vaccine or positive Hepatitis surface antibody meets the requirement)

A. Immunization

Dose #1 _____/_____ (M Y)  Dose #2 _____/_____ (M Y)  Dose #3 _____/_____ (M Y)

B. Hepatitis B surface antibody  Date _____/_____ (M Y)  Result: Reactive _______  Non-reactive _______

2. Meningococcal (One dose – preferably at entry into college for freshmen living in residence halls who wish to reduce their risk of meningococcal disease. Undergraduates less than 25 years old who wish to reduce their risk of disease can consider the vaccine. Students with immunodeficiency such as complement deficiency or asplenia should receive vaccine every 3-5 years.

Quadrivalent polysaccharide vaccine …………………….. Date _____/_____ (M Y)

3. Polio (Primary series in childhood meets requirements; three primary series schedules are acceptable.)

A. OPV alone (Oral Sabin three doses): #1 _____/_____ (M Y)  #2 _____/_____ (M Y)  #3 _____/_____ (M Y)

B. IVP alone (injected Salk four doses): #1 _____/_____ (M Y)  #2 _____/_____ (M Y)  #3 _____/_____ (M Y)  #4 _____/_____ (M Y)

C. IPV/OPV sequential: IPV #1 _____/_____ (M Y)  IPV #2 _____/_____ (M Y)  OPV #3 _____/_____ (M Y)  OPV #4 _____/_____ (M Y)

4. Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)

A. History of disease  Yes _____ No _____

B Varicella antibody _____/_____ (M Y)  Reactive _____  Non-reactive _____

C. Immunization

1. Dose #1  #1 _____/_____ (M Y)

2. Dose #2, given at least one month after first dose, if age 13 years or older  #2 _____/_____ (M Y)

**Health Care Provider**

Printed Name ________________________________________ Address ________________________________________

Signature ________________________________________ Phone (        ) ________________________________