

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 Received by August 17***

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 _____ Date _____
(if student is under age 18)

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 # _____

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: _____

Required Procedures

Urinalysis: _____
 Date _____
 Sugar _____
 Albumin _____
 Micro. _____
 Hemoglobin or Hematocrit: _____

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

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?		

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

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

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 / Dose #2 / Dose #3 /
M Y M Y M Y

B. Hepatitis B surface antibody Date / Result: Reactive Non-reactive
M Y

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 / #2 / #3 /
M Y M Y M Y

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

C. IPV/OPV sequential: IPV #1 / IPV #2 / OPV #3 / OPV #4 /
M Y M Y M Y 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 / Reactive Non-reactive
M Y

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 () _____