CATAWBA COLLEGE

To: New Students and Parents or Legal Guardians

From: Catawba College Proctor Foundation Health Services Center
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Welcome and congratulations on your acceptance to Catawba College. We look forward to meeting you and managing your health care while you are a student on our campus. Catawba College is interested in every phase of student life. An active Health Services Center is available and every effort is made to provide excellent health care. Some of our services are:

1. Management of acute problems by nurses in the Center, with easy access to physician by telephone.
2. Over the counter medication given at NO cost.
3. Laboratory testing, when ordered by physician, billed to your insurance company.

The Health Services Center is open Monday through Friday from 8 a.m. - 4:30 p.m.

Coverage on the weekends is handled by Rowan Regional Medical Center, the regional hospital, Pro-Med, and Romedical Center, walk-in clinics. There will be a charge for services rendered at either of these facilities which are located in Salisbury.

Attached, please find the Catawba College health form which **MUST be completed 30 days prior to** enrollment. Note that one side of the form (Health History) is to be completed by the student. The reverse side (Physical Examination and Immunization) **MUST BE COMPLETED BY A PHYSICIAN.**

PLEASE REMEMBER TO SEND A COPY OF YOUR INSURANCE CARD. If you have HMO insurance, please contact your insurance company requesting “guesting privileges”.

Return this form and a copy of your insurance card **NO LATER THAN 30 DAYS PRIOR TO ENROLLMENT** to:

Proctor Foundation Health Services Center
Catawba College
2300 West Innes Street
Salisbury, NC 28144-2488

It is required by North Carolina State Law (General Statutes 130A-157, as amended effective July 1, 1994) that this form be on file at the Health Services Center **BEFORE** registration. **Students not satisfactorily meeting immunization requirements will be subject to suspension from Catawba College.**

DO NOT MAIL UNTIL ALL PROCEDURES ARE COMPLETED AND ENTERED ON THIS FORM.

THIS FORM MUST BE COMPLETED AND RETURNED NO LATER THAN 30 DAYS PRIOR TO ENROLLMENT.

Catawba College
Health History
to be completed by Student

For Office Use Only
completed _____
2 week letter _____
insurance _____
NCIR _____

Please answer all questions. *Print or type*

Name ____ Sex ______ Age __________ Birth Date _______________
Last First Middle

Home Address ____ Phone ______________________________
Street City State Zip

Marital Status: S M W D Social Security Number ______________________ Student's Cell Number ______________________

Student's Personal E-Mail Address: ______________________________

A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD MUST ACCOMPANY THIS FORM.

HOSPITAL/ HEALTH INSURANCE: Student must be covered with personal or school insurance

INSURANCE COVERAGE MANDATORY Personal _________School _______

Is your Insurance an HMO? ☐ yes ☐ no; If yes, Name of Physician ____
Name Address Phone Number

CLASS YOU ARE ENTERING	PREVIOUSLY ENROLLED	PROPOSED REGISTRATION
☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior	☐ No ☐ Yes Date (s) ________	☐ Fall ☐ Spring ☐ Summer 20____

PERSONAL HISTORY: In order to better facilitate student care, please answer if you have ever had any of the following:

	yes	no		yes	no		yes	no
Arthritis			Rheumatic Fever			Ear, Nose, Throat Trouble		
Migraine			Heart Disease or Mumur			Anorexia Nervosa/ Bulimia		
Epilepsy (convulsive disorder)			High Blood Pressure			Hepatitis		
Asthma, Hayfever, Hives			Tuberculosis			Kidney Disease		
Other Allergic Conditions			Diabetes			Gastrointestinal Conditions		
Mononucleosis			Emotional Condition			Learning Disability		

Other serious illnesses/ hospitalizations/ injuries/ disabilities/ deformities: ______________________________

If any of the above are YES, give details: ______________________________

____

Any medical condition which will interfere with regular physical education or athletic participation? ______________

If so, what? ______________________________

Give name(s) and address(es) of doctor(s) and/ or hospital(s) or clinic(s): ______________________________

____

Any emotional condition, give name(s) and address(es) of doctor(s) and/ or hospital(s) or clinic(s): ______________

____

PRESENT ILLNESS: Any disease, drug or treatment that should be continued or evaluated periodically? ☐ yes ☐ no

If yes, please explain: ______________________________

DRUG ALLERGIES: ☐ yes ☐ no If yes, what drugs? ______________________________

EMERGENCY INFORMATION: In case of emergency, please notify: ______________________________
Name Address

Relationship ______________________ Phone ______________________________ Email ______________________

PARENT/ GUARDIAN of students under 18: I hereby authorize any medical treatment for my child which may be advised or recommended by the medical staff of the Catawba College Student Health Center.

Signature of Parent/ Guardian: ____ Date ______________

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 give my permission to any doctor, hospital, or other medical agency to release confidentially to the Student Health Center Physician(s) of Catawba College any information they may have concerning my medical condition and their professional contact with me.

Signature of Student: ____ Date ______________________

Name ________________

Proctor Student Health Center: Catawba College

IMMUNIZATION HISTORY- Part I

A - G Mandatory

N.C. STATE LAW REQUIRES THAT ANY STUDENT NOT PRESENTING PHYSICIAN-SIGNED IMMUNIZATION MUST BE IMMUNIZED DURING THE INITIAL 30 DAY OF THE SEMESTER. NON-COMPLIANCE REQUIRES REMOVAL FROM SCHOOL. COPIES OF THE N.C. HIGH SCHOOL IMMUNIZATION CERTIFICATION OR OFFICIAL DOCUMENTATION ARE ACCEPTABLE IF UP-TO-DATE.

A. TETANUS-DIPHTHERIA

Tetanus-Pertussis-Diphtheria **SERIES OF THREE DATES:** (MO) (DAY) (YR) (MO) (DAY) (YR) (MO) (DAY) (YR)

-AND-

Tdap (**WITHIN PAST 10 YEARS)** **Date of Vaccination:** (MO) (DAY) (YR)

B. MEASLES, MUMPS, RUBELLA (MMR) - TWO DOSES REQUIRED

Dose 1 - 4 days prior to or on 1st birthday **Date of Vaccination:** (MO) (DAY) (YR)

-AND-

Dose 2 - At least one month after 1st dose **Date of Vaccination:** (MO) (DAY) (YR)

IF MMR NOT GIVEN, PROCEED TO C, D AND E.

C. MEASLES (RUBEOLA) Check one (not required if born before 1/1/57)

1. Two does required **Date of Vaccination:** (MO) (DAY) (YR)

Dose 1-Immunization on or after 1st birthday

-AND- **Date of Vaccination:** (MO) (DAY) (YR)

Dose 2-At least one month after 1st dose

Date of Disease: (MO) (DAY) (YR)

2. Had disease; confirmed by office record

-OR- **Date of Titer:** (MO) (DAY) (YR)

3. Report of positive immune titer

D. RUBELLA - History of disease is NOT acceptable verification. Check one (not required if 50 years old or older) **Date of Vaccination:** (MO) (DAY) (YR)

1. Immunization on or after 1st birthday

-OR- **Date:** (MO) (DAY) (YR)

2. Has report of positive immune titer

E. MUMPS - Check one (not required if born before 1/1/57) **Date of Vaccination:** (MO) (DAY) (YR)

1. Immunization on or after 1st birthday

-OR- **Date of Disease:** (MO) (DAY) (YR)

2. Had disease; confirmed by office record

F. POLIO - **Last Booster Date:** (MO) (DAY) (YR)

1. Completed primary series ☐ no ☐ yes; Type of vaccine ☐ OPV ☐ IPV

G. **HEPATITIS B** **SERIES OF THREE DATES** **Dates: # 1** (MO) (DAY) (YR) **# 2** (MO) (DAY) (YR) **# 3** (MO) (DAY) (YR)

IMMUNIZATION HISTORY - Part II (Strongly Recommended)

MENINGITIS VACCINE **Date**: ______________
(recommended, not mandatory)

HEPATITIS A **Dates** #1 ______________ #2 ______________

HPV **Dates**: #1 ______________ **#2** ______________ **#3** ______________

VARICELLA **Date:** ______________

(Print or Type) Physician's Signature

PHYSICIAN'S NAME ____

Street Address City State Zip

ADDRESS ____

PHONE NUMBER ______________________________ **DATE** ______________

PLEASE MAIL COMPLETED FORM 30 DAYS PRIOR TO ENROLLMENT.

PHYSICAL EXAMINATION

Must be completed by Physician

NOTE: The student shall have a physical examination within the TWELVE (12) month period preceding date of entrance to Catawba. Students participating in VARSITY athletics MUST HAVE the physical examination within the three (3) month period preceding date of entrance to Catawba. Information on this form will be made available to college officials as deemed necessary for the student's well-being.

Name ____ Date of Birth _____________ Sport(s) ________________

Weight ____________________ Height ___________ Sex _________ Blood Pressure ______________ Pulse ____________

Eyes: Vision Right-- 20/___ Corrected to Right-- 20/___

Left-- 20/___ Left-- 20/___

	Normal	Describe Abnormality		Normal	Describe Abnormality
Head, Nose, Ears, Neck			Hernia		
Respiratory			Genitourinary		
Cardiovascular			Musculoskeletal		
Metabolic/ Endocrine			Skin		
Gastrointestinal			Emotional Disorders		

Is there loss or seriously impaired function of any organ? _____________ Comment(s) ______________________

Remarks pertinent to history or physical ______________________________________

Urinalysis:

Glucose ___________________ Albumin ___________________ Microscopic ___________________

Is student under treatment for any medical or emotional condition? ☐ Yes ☐ No Capable of unlimited athletic participation? ☐ Yes ☐ No

If No, Explain: ______________________________________

Recommendations or comments: ______________________________________

Please list all medications, dosage, and frequency:

Medications: ____________________ Dosage:________________________ Frequency:______________________________

Medications: ____________________ Dosage:________________________ Frequency:______________________________

Medications: ____________________ Dosage:________________________ Frequency:______________________________

Medications: ____________________ Dosage:________________________ Frequency:______________________________

Drug Allergies: ____

TUBERCULIN/ REQUIRED BY CATAWBA COLLEGE

Tuberculin skin test within a year of registration date **(MUST HAVE RESULT)** Result _______ Date: [ ] [ ] [ ] (MO) (DAY) (YR)

If student is known to be tuberculin positive or if this test result is positive, attach record of treatment/ Chest X-Ray

Signed ____, M.D. (Print Name) __________________________________, M.D.

Address:____

Phone: ____

Date of exam _____/_______/_______

ALL CATAWBA STUDENT ATHLETES MUST RECEIVE AND SHOW PROOF OF SICKLE CELL TESTING PER NCAA REQUIREMENTS.

All Catawba Freshmen and Transfer Student-Athletes must show proof of mandatory Sickle Cell Testing by attaching a copy of a diagnostic lab report here! Acceptable laboratory reports include Hemoglobin Solubility Test, Hemoglobin Electrophoresis, or High Performance Liquid Chromatography, (HPLC). A copy of the Sickle Cell Test done at birth is also acceptable to meet this requirement. International students must provide this documentation with English translation.