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: _____

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

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

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 SENSITIVITY: ☐ 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 - F 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-

Tetanus-Diphtheria-Booster (**WITHIN PAST 10 YEARS**) _____ **TDap** _____ **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)

1. Immunization on or after 1st birthday **Date of Vaccination:** (MO) (DAY) (YR)

-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

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		

ALL CATAWBA STUDENT ATHLETES must show proof of Sickle Cell Testing via an attached physician's note!

Sickle Cell Positive: _____Yes _____No Sickle Cell Trait ____ Yes ____No Student Athlete refused testing ____Yes ____ No

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:_____

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 _____/_____/_____