CHECKLIST

REQUIRED
1 - PERSONAL HEALTH HISTORY

2 - IMMUNIZATION RECORDS

3 - HEALTH INSURANCE CARD (COPY FRONT AND BACK)

OPTIONAL
1 - TB SCREENING - OPTIONAL BUT RECOMMENDED

2 - PHYSICAL EXAM - OPTIONAL BUT RECOMMENDED
To: New Students and Parents or Legal Guardians

From: Catawba College Proctor Foundation Health Services
Center Teresa Bivins, RN; Email: tjbivins17@catawba.edu
Phone: 704-637-4404  Fax: 704-637-4234

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 aspect 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 Health Center, and easy access to physician care when needed.
2. Over the counter medication provided at NO cost to the student.
3. In clinic and outside laboratory testing available.

The Health Center is open Monday through Friday from 8 a.m. - 4:00 p.m. Coverage after hours, on weekends and holidays is handled by Novant Health Urgent Care, Pro-Med Urgent Care, Fast-Med Urgent Care or through the Emergency Department at Novant Health Rowan Regional Medical Center. There will be a charge for services rendered at these facilities.

*Attached is the State of NC Immunization requirements for all students. The student immunization record must be completed and returned BEFORE you arrive on campus.
*Also attached is the Catawba College personal health history form that is required for all students. The form is to be completed and signed by the student or parent if student is under the age of 18.
*A physical exam is not required for admission but is OPTIONAL. A physical form is included for your convenience if desired.

Catawba College also requires that all students have health insurance. A copy of your insurance card is required in the Health Center as well as being on file in the Business Office. For your benefit, if you have an HMO Insurance, please contact your insurance company to request "guesting privileges".

**CATAWBA COLLEGE DOES NOT ACCEPT OUT OF STATE MEDICAID OR INTERNATIONAL HEALTH INSURANCE POLICIES**

Please return the required forms and a copy of your insurance card to the Proctor Health Center NO LATER THAN 30 DAYS PRIOR TO ENROLLMENT to:

1. Teresa Bivins, RN – tjbivins17@catawba.edu or Fax to 704-637-4234 or mail to:
2. Proctor Foundation Health Services Center
   2300 West Innes St.
   Salisbury, NC 28144-2844

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

Please answer all questions. Print or type

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age</th>
<th>Birth Date</th>
</tr>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Student ID</th>
<th>Student's Cell Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>S M W D</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Student's Personal E-Mail Address:</th>
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</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Personal</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**CLASS YOU ARE ENTERING**

<table>
<thead>
<tr>
<th>Freshman</th>
<th>Sophomore</th>
<th>Junior</th>
<th>Senior</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

**PREVIOUSLY ENROLLED**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
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</table>

**PROPOSED REGISTRATION**

<table>
<thead>
<tr>
<th>Fall</th>
<th>Spring</th>
<th>Summer 20</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Arthritis</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatic Fever</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Migraine</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Heart Disease or Murmur</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Epilepsy (convulsive disorder)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Asthma, Hayfever, Hives</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Other Allergic Conditions</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Diabetes</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Mononucleosis</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Emotional Condition</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 __________________
A - H 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

(most recent dose must be within last ten years)

- AND -

Tdap (one lifetime dose) Date of Tdap Vaccination:

(MO) (DAY) (YR)

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

Dose 1 - 4 days prior to or on 1st birthday

- AND -

Dose 2 - At least one month after 1st dose

Date of Vaccination:

(MO) (DAY) (YR)

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 doses required

Dose 1-Immunization on or after 1st birthday

- AND -

Dose 2-At least one month after 1st dose

Date of Vaccination:

(MO) (DAY) (YR)

Date of Vaccination:

(MO) (DAY) (YR)

Date of Disease:

(MO) (DAY) (YR)

Date of Titer:

(MO) (DAY) (YR)

2. Had disease; confirmed by office record

- OR -

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)

Date:

(MO) (DAY) (YR)

E. MUMPS - Check one (not required if born before 1/1/57)

1. Immunization on or after 1st birthday

- OR -

2. Had disease; confirmed by office record

Date of Vaccination:

(MO) (DAY) (YR)

Date of Disease:

(MO) (DAY) (YR)

F. POLIO

1. Completed primary series □ No □ Yes; Type of vaccine □ OPV □ IPV

G. HEPATITIS B

SERIES OF THREE DATES

(Not required if born before July 1, 1994)

Dates: # 1 # 2 # 3

(MO) (DAY) (YR) (MO) (DAY) (YR) (MO) (DAY) (YR)


Date of Vaccination:

(MO) (DAY) (YR)

Mandatory Physician Information

Physician’s Name

(Print or Type)

Physician’s Signature

Address

Street Address

City

State

Zip

Phone Number

(Date)
IMMUNIZATION HISTORY - Part II (Strongly Recommended)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENINGITIS VACCINE</td>
<td>____________ (recommended, not mandatory)</td>
</tr>
<tr>
<td>HEPATITIS A</td>
<td>#1 ____________ #2 ____________</td>
</tr>
<tr>
<td>HPV</td>
<td>#1 ____________ #2 ____________ #3 ____________</td>
</tr>
</tbody>
</table>

PLEASE SUBMIT COMPLETED FORM 30 DAYS PRIOR TO ENROLLMENT.
Name __________________________ Date of Birth ______________

Weight ___________________ Height __________ Sex _______ Blood Pressure _______ Pulse _________________

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Describe Abnormality</th>
<th></th>
<th>Normal</th>
<th>Describe Abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Nose, Ears, Neck</td>
<td></td>
<td>Hernia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td>Genitourinary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metabolic/ Endocrine</td>
<td></td>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td>Emotional Disorders</td>
<td></td>
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</tbody>
</table>

Is there loss or seriously impaired function of any organ? ___________ Comment(s) ________________________________

Remarks pertinent to history or physical __________________________________________________________________________
_________________________________________________________________________________________________________________________________________

Urinalysis:
Glucose _______________ Albumin _______________

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: _______________________________________________________________________________________

SIGNED ___________________________ , M.D. (Print Name) ___________________________ , M.D.

Address: _____________________________________________________________________________________________

Phone: _____________________________________________________________________________________________

Date of exam _______ / _______ / _______
M. Record of Tuberculosis Screening (DHHS 3405)

Department of Health and Human Services  
Division of Public Health  
Epidemiology Section • TB Control

Record of Tuberculosis Screening

Name ________________________________________________

Sex _______ Race ____________________________ Birthdate _______ / _______ / _______ 

Date

Section A.

Answer the following questions.

<table>
<thead>
<tr>
<th>Do you have:</th>
<th>Descriptions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unexplained productive cough</td>
<td>Cough greater than 3 weeks in duration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Unexplained fever</td>
<td>Persistent temp elevations greater than one month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Night sweats</td>
<td>Persistent sweating that leaves sheets and bedclothes wet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Shortness of breath/Chest pain</td>
<td>Presently having shortness of breath or chest pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Unexplained weight loss/appetite Loss</td>
<td>Loss of appetite with unexplained weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Unexplained fatigue</td>
<td>Very tired for no reason</td>
<td></td>
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</tr>
</tbody>
</table>

The above health statement is accurate to the best of my knowledge. I will see my doctor and/or the health department if my health status changes.

__________________________________________________         ____/_____/_____

Signature          Date   Witness

Section B.

This is to certify that the above-named person (a) had a tuberculin skin test on____ / ____ / ____ which was read as ____________mm., and (b) had a chest X-ray done on____ / ____ / ____ which showed no sign of active inflammatory disease. This person has no symptoms suggestive of active tuberculosis disease. A chest X-ray for tuberculosis is not indicated.

__________________________________________________         ____/_____/_____

Licensed Medical Professional          Date