CATAWBA COLLEGE

PROCTOR STUDENT HEALTH CENTER

CHECKLIST

REQUIRED

1 - PERSONAL HEALTH HISTORY

2 - IMMUNIZATION RECORDS
(Attached Form or Official Immunization Record Accepted)

3 - HEALTH INSURANCE CARD (COPY FRONT AND BACK)

4 - EVIDENCE OF A NEGATIVE COVID TEST
(Taken No More than Five (5) Calendar Days Prior to Arrival)

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. Upload documents in CatLink using the “Health Services Document Upload” link, located under the “Services” tab in the Health Services information.
2. Submit to Teresa Bivins, RN-Director Proctor Student Health Center tjbivins17@catawba.edu or Allison Wilson, RN, BSN-cbarring20@catawba.edu
3. Fax to 704-637-4234
4. Mail to:
   Proctor Student Health Center
   2300 West Innes St.
   Salisbury, NC 28144

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.**

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 Student ID_____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 _____

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 Murmur			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:**

DOB_____ **Catawba College IMMUNIZATION HISTORY- Part I**

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 **SERIES OF THREE DATES:**

Tetanus-Pertussis-Diphtheria
(most recent dose must be within last ten years)

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

-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 **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)
(Not required if born before July 1, 1994)

H. VARICELLA – Required if born on/after April 1, 2001.

Dates: #1 (MO) (DAY) (YR) **# 2** (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)

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

HEPATITIS A **Dates** #1 _____ #2 _____

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

PLEASE SUBMIT COMPLETED FORM 30 DAYS PRIOR TO ENROLLMENT.

PHYSICAL EXAMINATION

Must be completed by Physician

(OPTIONAL)

Name_____Date of Birth_____

Weight_____Height_____Sex_____Blood Pressure_____Pulse_____

	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 _____

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_____/_____/_____

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.

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

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*