CHECKLIST

---------------------------------REQUIRED---------------------------------

1 - PERSONAL HEALTH HISTORY

2 - IMMUNIZATION RECORDS
   Attached Form or Official Immunization Record Accepted

3 - HEALTH INSURANCE CARD
   Copy Front and Back

---------------------------------OPTIONAL---------------------------------

1 – COVID-19 VACCINATION – OPTIONAL BUT STRONGLY ENCOURAGED

2 - TB SCREENING - OPTIONAL BUT RECOMMENDED

3 - 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. **Email** to healthcenter@catawba.edu
2. **Fax** to 704-637-4234
3. **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

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

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

PREVIOUSLY ENROLLED

☐ No ☐ Yes Date(s) ________

PROPOSED REGISTRATION

☐ Fall ☐ Spring ☐ Summer 20____

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>Migraine</td>
<td>Heart Disease or Murmur</td>
</tr>
<tr>
<td>Epilepsy (convulsive disorder)</td>
<td>High Blood Pressure</td>
</tr>
<tr>
<td>Asthma, Hayfever, Hives</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Other Allergic Conditions</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Mononucleosis</td>
<td>Emotional Condition</td>
</tr>
<tr>
<td>Other serious illnesses / hospitalizations / injuries / disabilities / deformities:</td>
<td>COVID-19 Vaccine</td>
</tr>
</tbody>
</table>

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 __________________________
### 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:**

<table>
<thead>
<tr>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>(MO)</td>
<td>(DAY)</td>
<td>(YR)</td>
</tr>
<tr>
<td>(MO)</td>
<td>(DAY)</td>
<td>(YR)</td>
</tr>
<tr>
<td>(MO)</td>
<td>(DAY)</td>
<td>(YR)</td>
</tr>
</tbody>
</table>

Tdap (one lifetime dose)

Date of Tdap Vaccination: [ ]

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

- **Dose 1** - 4 days prior to or on 1st birthday
- **Dose 2** - At least one month after 1st dose

Date of Vaccination: [ ]

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

1. Two does required
   - **Dose 1** - Immunization on or after 1st birthday
   - **Dose 2** - At least one month after 1st dose
2. Had disease; confirmed by office record
3. Report of positive immune titer

Date of Vaccination: [ ]

#### 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
2. Has report of positive immune titer

Date of Vaccination: [ ]

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

1. Immunization on or after 1st birthday
2. Had disease; confirmed by office record

Date of Vaccination: [ ]

#### F. POLIO

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

Last Booster Date: [ ]

#### G. HEPATITIS B - SERIES OF THREE DATES (Not required if born before July 1, 1994)

<table>
<thead>
<tr>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>(MO)</td>
<td>(DAY)</td>
<td>(YR)</td>
</tr>
<tr>
<td>(MO)</td>
<td>(DAY)</td>
<td>(YR)</td>
</tr>
<tr>
<td>(MO)</td>
<td>(DAY)</td>
<td>(YR)</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Date 1</th>
<th>Date 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>(MO)</td>
<td>(DAY)</td>
</tr>
<tr>
<td>(MO)</td>
<td>(DAY)</td>
</tr>
</tbody>
</table>

### 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)

COVID-19 VACCINE*
(strongly recommended)
Pfizer, BioNTech, or Moderna - Date: ___________  Date__________
Johnson & Johnson/Janssen - Date: ________________

*Please submit record of vaccination to healthcenter@catawba.edu.

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.
Name ___________________________ Date of Birth __________________

Weight ___________________ Height ___________ Sex _________ Blood Pressure ___________ Pulse ________________

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

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

Remarks pertinent to history or physical ________________________________________________________________

Urinalysis:

<table>
<thead>
<tr>
<th>Glucose</th>
<th>Albumin</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Medications: ____________________</th>
<th>Dosage: ____________________</th>
<th>Frequency: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications: ____________________</td>
<td>Dosage: ____________________</td>
<td>Frequency: ____________________</td>
</tr>
<tr>
<td>Medications: ____________________</td>
<td>Dosage: ____________________</td>
<td>Frequency: ____________________</td>
</tr>
<tr>
<td>Medications: ____________________</td>
<td>Dosage: ____________________</td>
<td>Frequency: ____________________</td>
</tr>
</tbody>
</table>

Drug Allergies: ________________________________

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

Address: ______________________________________________________________________

Phone: ______________________________________________________________________

Date of exam __________ / __________ / __________
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</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>
<td></td>
</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