Appalachian State University

M.S. Shook Student Health Service

ASU Box 32070, 614 Howard Street
Boone, NC 28608
Phone: 828-262-3100
Fax: 828-262-6958
www.healthservices.appstate.edu

Welcome to Appalachian State University. We look forward to helping you meet your healthcare needs as you embark on an exciting educational experience.

The Report of Medical History and Immunization Record forms will become a part of your Health Service medical record. Your past medical history will enable us to provide more informed and timely care for you when you visit.

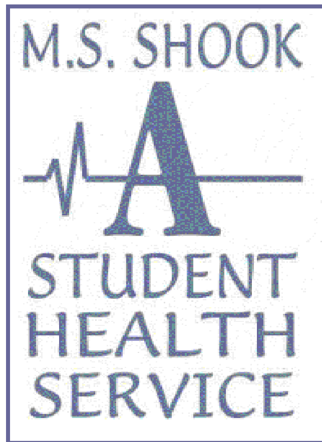
The Immunization Record will verify that you are in compliance with North Carolina law and University Policy.

- **Completion of these forms is required to finalize your acceptance to Appalachian State University.**
- **It is recommended that the completed forms be sent to the Health Service prior to attending orientation. However, they must be turned in no later than the following dates:**
    - **Spring Semester entrants - November 10**
    - **Fall Semester entrants - July 1**
- **If immunization requirements are not met, you will not be able to begin classes for the term.**

Forms should be sent to the health service address listed below:

M.S. Shook Student Health Service
614 Howard Street
ASU P.O. Box 32070
Boone, NC 28608-2070

If you have questions, our Medical Records staff will be happy to assist you. Please call us at 828-262-6578



Report of Medical History

A physical examination is not required.

***Complete this entire form and return prior to enrollment to*:**
Mary S. Shook Student Health Service
ASU Box 32070
Boone, North Carolina 28608-2070
ATTN: Medical Records
Phone: 828.262.6578

All Appalachian State University students must submit a Report of Medical History and Immunization Record Form, as required by University Policy and North Carolina law, before attending classes.

M. S. Shook Student Health Service Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

► Protected health information may be used by Health Service staff and disclosed to other Health Service staff in your treatment and Health Service operations, including, but not limited to, records maintenance, research and staff training. Such information also may be:
1. Used to secure payment for services rendered or products provided by the Health Service;
2. Used to confirm your visit to the Health Service on a given date upon inquiry by a faculty member; no other information will be given in response to such inquiries from faculty.
3. Exchanged between the Health Service and the Training Room staff in the treatment of varsity athletes.

► No one, including your parents, outside providers of health care, or faculty, has access to your protected health information without your written permission, except as required by law (Examples: reporting of certain communicable diseases to the NC Department of Health and Human Services or responding to a lawfully issued court order).

► To protect the confidentiality of your written medical information, these directives are followed:
1. You must complete the "Authorization to Release Patient Medical Information" before copies will be released to you or a third party.
2. FAXing medical information will be done ONLY in situations of medical urgency.
3. The use of e-mail in sharing your medical information is limited to general information and clarification about your medical care.
4. Correspondence about you from other health care providers to the Health Service is not released.

► You have the right:
1. To request restrictions on the uses and disclosures of your medical information, though the Health Service may not agree;
2. To receive confidential communications of protected health information;
3. To inspect, copy, and/or request amendment of your protected health information;
4. To receive an explanation of how your protected health information has been disclosed;
5. To revoke any prior authorization for use or disclosure of your protected health information through a written statement to the extent permitted by applicable laws or regulations;
6. To obtain a paper copy of this Privacy Notice upon request; and
7. To file a complaint with the M.S. Shook Student Health Service or the Secretary of the United States Department of Health and Human Services if you feel your privacy rights have been violated.

► To obtain further information or to exercise any of your rights, please contact the Privacy Officer of the Health Service at 828-262-3100. All employees of Appalachian State University are prohibited from retaliating against you for filing a complaint or exercise of your other rights under law or University policies.

The M. S. Shook Student Health Service is required by law to maintain the privacy of protected health information and to provide notice of its legal duties and privacy practices with respect to this information. Additionally, the Health Service is required to abide by the terms of the notice currently in effect.

The Health Service reserves the right to change the terms of the notice and make the changes effective for all protected health information that it maintains. In a timely manner, the revised notice will be published on the Health Service web site, placed at the sign-in areas of the Health Service, and distributed by paper copy upon request.

www.healthservices.appstate.edu

Appalachian STATE UNIVERSITY

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Be certain that your Name, Date of Birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and the year.

Please Keep a Copy for Your Records.

Acceptable Records of your Immunizations may be obtained from any of the following:

- High School Records – These may contain some, but not all of your immunization information. Contact Student Health for help if needed. **Your immunization records do not transfer automatically. You must request a copy for health services**
- Personal Shot Records – Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department
- Military Records of WHO (World Health Organization Documents) - These records may not contain all of the required immunizations.
- Previous College or University – **Your immunization records do not transfer automatically. You must request a copy for health services**
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SECTION A: COLLEGE/UNIVERSITY VACCINES AND NUMBER OF DOSES REQUIREMENTS

(For further information: http://www.immunizenc.com/college.htm)

VACCINE REQUIRED (REVIEW ALL FOOTNOTES BELOW)	Diphtheria, Tetanus, and/or Pertussis [1]	Polio [2]	Measles [3]	Mumps [4]	Rubella [5]
DOSES REQUIRED	3	3	2	2	1

FOOTNOTE [1] – DTP (Diphtheria, Tetanus, Pertussis), DTaP (Diphtheria, Tetanus, acellular Pertussis), Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, Pertussis): 3 doses of tetanus/diphtheria toxoid of which **one must have been within the past 10 years**.

Those individuals enrolling in college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid and a booster dose of tetanus/diphtheria/pertussis vaccine if a tetanus/diphtheria toxoid or tetanus/diphtheria/pertussis vaccine has not been administered with the past 10 years.

FOOTNOTE [2] – An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

FOOTNOTE [3] – Measles vaccines are not required if any of the following occur: Physician diagnosis of disease prior to January 1, 1994; An individual who has been documented by serological testing to have a protective antibody titer against measles and submits the lab report . Or the student is 50 years of age or older.

FOOTNOTE [4] – Mumps vaccine is not required if any of the following occur: An individual who has been documented by serological testing to have a protective antibody titer against mumps and submits the lab report; Or the student is 50 years of age or older.

FOOTNOTE [5] – Rubella vaccine is not required if any of the following occur: 50 years of age or older;; An individual who has been documented by serological testing to have a protective antibody titer against rubella and submits a lab report.

INTERNATIONAL STUDENTS and/or non-US Citizens: Vaccines are required as noted above. Additionally, these students are required to have a TB skin test (PPD or TST) that has been administered and read at an appropriate medical facility within the 12 months prior to the first day of classes (chest x-ray required if test is positive).

SECTION B

These vaccines are RECOMMENDED. Some may be required by certain departments. Consult your college or department for specific requirements.

North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Attached to this form is information regarding meningococcal disease, including recommendations from the Centers for Disease Control of the U.S. Public Health Service. Please record on the front of this form, whether or not you have received the meningococcal vaccine. If, yes, please note the month, day, and year of the vaccination.

SECTION C

These vaccines are optional

FORM UPDATED 9/2008

IMMUNIZATION RECORD

Last Name First Name Middle Name	Date of Birth	Student ID#

Please print in black ink. To be completed and signed by physician or clinic. A complete official immunization record from a physician or clinic may be attached to this form. **Student to confirm identifying information above is complete before submission.**

SECTION A Required Immunizations	mo/day/year	mo/day/year	mo/day/year	mo/day/year	
* DTP or Td or Tdap	(#1)	(#2)	(#3)	(#4)	
***Tdap booster (If due update after 7/2008)**					
* Td booster					
* Polio					
* MMR (after first birthday)					
* Measles/ Rubella (MR) (after first birthday)					
* Measles (after first birthday)			** Disease Date	Titer Date & Result	SUBMIT LABORATORY REPORT
* Mumps			Not Acceptable *** Disease Date	Titer Date & Result	
* Rubella			Not Acceptable *** Disease Date	Titer Date & Result	

SECTION B Recommended Immunizations

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

Meningococcal vaccine: No ( )Yes( ) Which vaccine? Menactra ( ) Menomune ( ) Date given:

	mo/day/yea	mo/day/yea	mo/day/yea	mo/day/yea
* Hepatitis B series only				****Titer Date & Result
OR				
* Hepatitis A/B combination series				
*Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
* Tuberculin Skin Test (PPD) Date read				
(within 12 months) **Report result in mm induration**				
Chest X-Ray, if positive PPD Date				
Results				
Treatment if applicable Date				

SECTION C Optional Immunizations	mo/day/year	mo/day/year	mo/day/year
* Haemophilus influenzae type b			
* Pneumococcal			
* Hepatitis A series only			
* HPV (Gardasil)			
* Other			

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner — Date

Print Name of Physician/Physician Assistant/Nurse Practitioner — Phone number

Office Address — City — State — Zip Code

** Must repeat Rubeola (measles) vaccine if received more than 4 days prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

*** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

**** Lab Report must be submitted.

FORM UPDATED 9/2008

Information about Meningococcal Disease and Meningococcal Vaccine from the M. S. Shook Student Health Service

The following information regarding meningococcal disease and meningococcal vaccine is based on guidelines established by the American College Health Association and the Centers for Disease Control and Prevention (CDC).

Meningococcal disease continues to pose a small but definite risk to college students, with 100 to 125 cases occurring on campuses across the nation each year, resulting in 5 to 15 deaths. The disease is caused by the bacteria, *Neisseria meningiditis,* and is transmitted through the air by tiny droplets from the respiratory tract of an infected person, through sharing contaminated items such as cigarettes or drinking glasses, or by direct contact, such as kissing.

If infected, a person may experience any of the following:

- high fever
- rash
- nausea
- vomiting
- severe headache
- neck stiffness
- lethargy
- light sensitivity

The disease tends to occur in late winter and early spring, overlapping the flu season. The infection progresses rapidly, making early medical care essential.

The vaccine against meningitis is 85% to 100% effective for the group of germs that account for 70% of the disease. Immunity begins 7-10 days after vaccination and lasts 3-5 years.

Contact your personal physician for further information about meningitis and the vaccine's availability in your community.

If you wish to be vaccinated and are unable to be given the immunization before you come to campus, the vaccine is available at cost through the Health Service during summer orientation and early fall months.

Should you have any questions regarding meningococcal disease or the vaccine once you arrive on campus, please feel free to contact the Health Service or visit our website at www.healthservices.appstate.edu.

REPORT OF MEDICAL HISTORY *(Please print in black ink)* *To be completed by student*

LAST NAME (print) FIRST NAME MIDDLE NAME ASU ID#

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo/day/yr)_______________ GENDER M ___ F___ T___ MARITAL STATUS S___ M___ OTHER___ EMAIL_________________________

CLASS YOU ARE ENTERING (circle):
FR. SO. JR. SR. GRAD. PROF.

PREVIOUSLY ENROLLED HERE ☐ YES ☐ NO
IF YES, DATES: ________________________________

SEMESTER ENTERING (circle): FALL SPRING
SUMMER 1 SUMMER 2 OTHER YEAR 20____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

NAME OF POLICY HOLDER EMPLOYER

IS THIS AN HMO/PPO/MANAGED CARE PLAN? ☐ YES ☐ NO

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY & PERSONAL HEALTH HISTORY *(Please print in black ink)* *To be completed by*

Has any person, related by blood, had any of the following:

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT ___________ WEIGHT ___________

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			

	Y	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted disease			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack cigarettes/week			
Regularly exercise			
Wear seat belt			
Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name ____________________ Use ___________ Dosage _________ Name ____________________ Use ___________ Dosage _________

Name ____________________ Use ___________ Dosage _________ Name ____________________ Use ___________ Dosage _________

Name ____________________ Use ___________ Dosage _________ Name ____________________ Use ___________ Dosage _________

Name ____________________ Use ___________ Dosage _________ Name ____________________ Use ___________ Dosage _________

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

FAMILY AND PERSONAL HEALTH HISTORY – CONTINUED (*please print in black ink*) *To be completed by student*

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION….PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise required by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. (Not applicable to community colleges.)

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. (Not applicable to community colleges.)

(D) I acknowledge I have received, read, and understand the M. S. Shook Student Health Service *Privacy Notice* and *Information about Meningococcal Disease and Meningococcal Vaccine.*

Signature of Student **Date**

Signature of Parent/Guardian, if student under age 18 **Date**