Livingstone College
Student Health Center

701 W. MONROE ST.
SALISBURY, NC 28144
Phone: 704-216-6111 Fax: 704-216-6770

Dear Perspective Student:

On behalf of the Health Services team we would like to welcome you to Livingstone College. This letter is an aid to help you get your health records completed and turned in **30 days prior to enrollment**. In the health packet there will be:

- **Page 1**- contains the medical history for the student. All blanks should be filled in- including insurance status, along with a copy of the insurance card and drug allergy information. The student should fill in this portion; or a parent or guardian may do so if the student is under the age of 18.
- **Page 2-** is the physical portion and is filled in by the physician. Your physical must have been completed within a 12 month period. The physician may or may not perform a urinalysis or perform labs. It is dependent upon the health of the student.
- **Page 3-**immunization page. Immunization records must be signed by a Physician or Nurse Practitioner including the address and phone number of the provider. A Tuberculosis Skin test is required for admission. For North Carolina students a high school transcript is not an acceptable record of immunization. Immunization records must be received on or before the student first registers for classes.
- **Page4**-Meningococcal vaccine declination page. Sign if you do not wish to receive the vaccine.

North Carolina State Law Immunization Requirements

Immunization requirements apply to all students **except** those residing off campus and registering for any combination of: off campus courses, evening courses (those which start after 5pm), weekend courses and taking no more than 4 credit hours in on campus courses. If at any time any of the above changes, the student needs to submit a certificate of immunization on or before the first date of registration.

- **Tetanus- DTP, DT, TD/TDap**- series of (3) doses. Under administrative rule **10A NCAC 41A.0401** those students entering a college or university for the first time after July 1, 2008 are required to have a booster dose of TDap (tetanus/diphtheria/acellular pertussis) within the past 10 years.
- **Polio**-a series of (3) doses. Not required if over the age of 18.
- **MMR** (measles, mumps and rubella) 2 doses.
- **Hepatitis B**-a series of 3 doses required for those students born 1994 and after.

Recommended Immunizations

- Meningococcal-if student doesn't want to take vaccine, please sign the vaccine declination sheet.
- HPV
- Hepatitis A
- Varicella

If a student must begin a series of injections in order to be in compliance; such will be completed before the student can legally remain in college. Those students that do not turn in immunization records prior to enrollment will be given 30 calendar days from the first day of classes in order to become compliant. **If after that time, they will be withdrawn from classes, will not be able to participate in sports and cannot live in the Residence Halls.**

*****Your health packet contains a self addressed envelope for Health Services**. Please mail your forms directly to Health Services!**

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Demographics (TO BE COMPLETED BY THE STUDENT)

NAME: Last_____First_____Middle initial_____Date of Birth_____

HomeAddress:_____City_____

State_____zip_____Cell/Home Phone: ( )_____

Emergency Contact: (name, phone number)_____

Proposed Registration (please check) Fall___Spring_____Summer_____Year_____Previously enrolled? Y_____N_____Year_____

Are you covered with Medical Insurance? Y_____N_____If yes, please provide a copy of the front and back of your insurance card.

Are you allergic to any medications? Y_____N_____If so, please list the name and type of reaction_____

Is there any disease or treatment that should be evaluated periodically? If so, please explain_____

Personal Health History

Do you have a history of any of the following? Y=yes N=no

Anorexia_____

Arthritis_____

Asthma/Hay Fever/Hives_____

Diabetes_____

Ear/Nose or Throat trouble_____

Eczema_____

Emotional Conditions _____

Epilepsy (Seizures) _____

Gastrointestinal Disorder_____

Heart Disease_____

Hepatitis_____

High Blood Pressure_____

Kidney Disease_____

Migraine Headache_____

Mononucleosis_____

Sickle Cell Trait_____

Statement by student, Parent or Legal Guardian (if student under the age of 18): I attest that the submitted health information above is true and complete to the best of my knowledge. I hereby give permission to any physician, Hospital or other medical agency as appropriate to advise and render medical treatment as necessary.

Signature of Student_____or Legal Guardian_____Date:_____

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PHYSICAL EXAMINATION

(TO BE COMPLETED BY PHYSICIAN, PA, FNP, OR CERTIFIED CLINICAN)

Name_____Date of Birth_____

BP_____Pulse_____HT_____WT_____BMI_____

Vision: Right-20/_____Left-20/_____ Corrected to: Right 20/_____Left-20/_____

SYSTEM	NORMAL	ABNORMAL	COMMENTS
HEENT			
RESPIRATORY			
CARDIOVASCULAR			
METABOLIC/ENDOCRINE			
GASTROINTESTIONAL			
HERNIA			
G/U			
MUSCULOSKELETAL			
NEUROPSYCHIATRY			
SKIN			

Any loss or serious impairment to any organ? _____

Is Student being treated for medical or emotional condition? _____

Is Student capable of unlimited athletic participation? _____

Remarks pertinent to history or physical findings_____

Signature of Physician_____Date_____

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LABORATORY

HEMOGLOBIN_____

URINALYSIS: GLUCOSE_____ALBUMIN_____

REQUIRED IMMUNIZATIONS

Name: _____**Date of Birth**: _____

DTP, DTap, TD (*proof of **3 doses** required*) 1._____2._____3._____4_____5_____

TD/Tdap (*Tdap required for all freshmen, TD within the last 10 years) 1.*_____

POLIO (*a series of **3**. If over the age of 18 not required*) 1._____2._____3._____4._____5._____

MMR-Measles, Mumps and Rubella (*a series of **2**. The first dose must have been given on or after the first birthday. Not required after the age of 50). Serological titers acceptable to verify immunity. 1.*_____2._____

HEPATITIS B (*a series of 3. If born after 1994)1.*_____2._____3._____

TB SKIN TEST (*required within the past year*.) Tuberculin lot #_____Exp. date_____Given by: _____

Date given: _____Date read: _____Result:_____

******If there is a history of a positive TB test in the past, please provide chest x-ray results. ******

RECOMMENDED IMMUNIZATIONS

MENINGOCOCCAL (*A dose of **1.** If the first dose was given at age 13 through 15 years, a one -time booster dose should be administered at 16-18 years*)

1._____2._____

Which dose administered? (Please check) Menactra_____Menveo_____

HPV-GARADSIL (*a series of **3** for females and males up to the age of 26)* 1._____2._____3._____

VARICELLA (*series of **2** for those with no history of chickenpox*) 1._____2._____

HEPATITIS A (*series of **2**) 1.*_____2._____

PHYSICIAN SIGNATURE OR CLINIC STAMP_____**DATE** _____

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MENINGOCOCCAL VACCINE WAIVER FORM

MUST BE COMPLETED AND SUBMITTED IF STUDENT DOES NOT RECEIVE VACCINE

MENINGOCOCCAL DISEASE (Meningitis) Meningococcal disease is a bacterial infection caused by the *Neisseria meningitidis*. The bacteria colonize in the inner lining of nasal passages. From there they can make their way into the bloodstream. If the bacteria multiply very quickly in the bloodstream this can lead to a severe blood infection called meningococcemia. The bacteria can also get carried to the brain and spine where they can attack the membranes covering the brain and spinal cord. These membranes are called meninges. This causes swelling. When this happens the disease is referred to as bacterial meningococcal meningitis. The disease is rare; however its initial flu-like symptoms make diagnosis difficult. Meningococcal bacteria are spread from person to person through close contact. The disease progresses rapidly and leads to death within 24-48 hours from the first sign of symptoms. Infants and adolescents are particularly vulnerable. Adolescents are at higher risk of contracting meningococcal disease because of several social and environmental factors such as: crowding, kissing, pubs/clubs, and residence halls. In the United States, the annual estimated incidence of meningococcal disease in adolescents and young adults (14-24 years old) was observed to be 0.75 cases per 100,000 individuals.

Vaccination is considered to be the most effective method of preventing meningococcal disease. A number of different vaccines are currently available for bacteria types A, C, W-135 and Y. Presently there is no vaccine available to protect against type B bacteria. In January 2011, the Advisory Committee on Immunization Practices (ACIP) recommended routine vaccination with a single dose vaccine for adolescents, optimally at age 11 or 12 years followed by revaccination at age 16 years, 5 years after the first dose received because there is a potential decline of immunity after 5 years.

Additional information can be obtained on the Centers for Disease Control and Prevention (CDC) website at: http://www.cdc.gov/health/diseases.htm.

Student Name (please print) Last_____First_____MI_____

Student ID number_____**Date of Birth**_____

If student is under the age of 18, parent or legal representative please sign:

Name: _____relation to student_____

I have read the information on meningococcal disease and:

(Mark either A or B)

A. I **DO NOT** wish to receive the meningococcal vaccine.

B. I have already received the vaccine on this date: _____.

Student Signature (over the age of 18)_____