Wake Forest University
2016-2017 Health Information & Immunization Form

North Carolina General Statute §130A 152-157 requires that ALL students entering college present a certificate of immunization which documents that the student has received the immunizations that are required by law. This documentation must be signed by a healthcare provider and include an office address. **Students may be withdrawn from the university** 30 days after classes begin if the mandatory immunization and TB requirements have not been met.

Deadlines for submission OF ALL 5 PAGES:

Fall admission – July 1
Spring admission – January 1
Summer admission – May 1

Basic Instructions:

- All Immunization records are required to be submitted in, or translated into English, and in MM/DD/YYYY format.
- Include name and Wake ID number on all forms.
- Forms completed at a doctor's office, clinic or health department must contain an "official Stamp" and/or clinician signature for documents to be complete and accepted.
- KEEP A COPY FOR YOUR RECORDS.

The following steps are MANDATORY:

- **Step 1:** Have a doctor's office, clinic or health department complete the Immunization Form.
- **Step 2:** Complete the Tuberculosis Questionnaire -**All incoming students must be screened for Tuberculosis risk factors through a screening questionnaire**
- **Step 3:** Mail or email the completed Immunization Requirements Form and TB Screening Questionnaire to:

Wake Forest University Student Health Service
P.O. Box 7386
Winston-Salem, NC 27109
OR
hiif@wfu.edu

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

- **Personal shot records** – Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- **High School Records** – These may contain some, but not all of your immunization records. Your immunization records do not transfer automatically. You must request a copy.
- **Local Health Department**
- **Previous College or University Records** – Your immunization records do not transfer automatically. You must request a copy.
- **Military Records or WHO (World Health Organization) Documents** – These records may not contain all of the required immunizations.

IMPORTANT! Your information will be reviewed by staff. You will be notified via post card or email if additional information is needed. Keep a copy for your records. There are occasions when you may need to resubmit your documentation.

Information about Meningococcal disease and Meningococcal vaccine can be found on the Student Health Service web page at shs.wfu.edu

Wake Forest University Student Health Service
P.O. Box 7386 | Winston-Salem, NC 27109
Office: (336) 758-5218

2016-2017 Health Information & Immunization Form

Confidentiality: Student medical records are confidential. Medical records and information contained in the records may be shared with therapists and physicians who are involved in the student's care, and otherwise will not be released without the student's permission except as allowed by law. Students who wish to have their medical records or information released to other parties should complete a release of information form at the time of each office visit or service.

Deadline: Fall admission – July 1, Spring admission – January 1, or Summer admission – May 1.
Do not submit until all forms are completed.

To be completed by Student **If completing by hand, please use black ink.**

Last Name	First Name	Middle Initial	Preferred name	Date of Birth	WFU ID#

Permanent Address _____
Street City State Zip Code

Cell Phone _____ Email Address _____
area code

Gender: _____Male _____Female _____ Transgender _____Age Marital Status: _____Single _____Married _____ Domestic Partner

USA Citizen?_____ Yes _____ No If no, what is your nationality: _____

Class you are Entering: _____ Fr. _____ So. _____ Jr. _____ Sr.
_____ Graduate School of Arts & Sciences _____ School of Law
_____ Graduate Schools of Business _____ School of Divinity
Semester Entering: _____ Fall _____ Spring _____ Summer Year _____
Previously Enrolled at WFU? _____ Yes _____ No

In case of Emergency, contact: _____ Relationship _____

Cell Phone _____ Home Phone _____ Bus. Phone _____
area code area code area code

Address _____
Street City State Zip Code

Email Address _____

Health Insurance Information Required or Submit Copy of Both Sides of Insurance ID Card
You must visit http://sip.studentlife.wfu.edu/ to complete the health insurance enrollment/waiver form, in addition to completing this section.
If you have questions about this process please send email to sip@wfu.edu

Insurance Company. _____ Subscriber's ID No. _____ Group No. _____

Subscriber's Name: _____ Ins. Co. Phone Number: _____

Address of Ins. Co. _____

Important Information—Please read and complete:

Authorization and Consent: Please read and sign below. **If the student is under the age of 18, a parent or guardian must also sign.** I agree that the attending physician or whomever he or she may designate may evaluate and treat all injuries or illnesses for which help is sought. In the case of a minor student, (under the age of 18) this treatment may proceed without prior notification of the undersigned parent or guardian. I also agree that needed immunizations may be administered. I further agree that the Student Health Service may release any medical information to other health care providers who are involved in my care.

_____ Date _____ / _____ /_____
Signature of Student

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

Last Name	First Name	Middle Initial	Preferred name	Date of Birth	WFU ID#

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Family Medical History

Have any of your relatives ever had any of the following?

	Yes	Relationship
Alcohol or drug abuse		
Asthma		
Cancer (type)		
Diabetes		
Heart disease		
Hereditary disease		
High blood pressure		
Migraine headaches		
Mental health condition		
Are you adopted?		

PERSONAL HISTORY

Comment on all positive answers below.

Are you allergic to:	Yes
Penicillin	
Sulfonamides	
Peanuts	
Bees, wasps	
Other medications/foods	
Specify:	
Do you receive allergy injections?	

Have you had:	Yes
Mononucleosis	
Chickenpox	
Hepatitis B	
Hepatitis C	
HIV	
Hearing disabilities	
Vision problems	
Corrective lenses	
Asthma	
Respiratory disorder	
Heart disease	
High blood pressure	
Stomach or intestinal disorders	
Menstrual cycle disorders	
Kidney disease	
Sexually transmitted diseases	
Anemia	
Blood disorders	
Diabetes	
Thyroid disease	
Other endocrine disorders	

Have you had:	Yes
Headaches	
Migraines	
Neurological disorder	
Seizures	
Alcohol abuse problems	
Other drug use problems	
Smoking/tobacco use	
Eating disorder	
Depression	
Anxiety	
ADD, ADHD	
Diagnosed learning disorder	
Other psychological disorder	
Cancer	
Chronic medical condition	
Specify:	
Surgery or serious injury	
Serious head injury	
Concussion	
Mobility disorder	
Organ loss	
Victim of personal assault, rape	

Current prescription medicines – list

Current non-prescription medicines – list

	Yes
A. Have you received treatment or counseling for a psychiatric or psychological problem (e.g. depression, eating disorders, anxiety)? *Please document below.*	
B. Have you had any illness or injury or been hospitalized other than already noted? *Please document below.*	

	Yes
C. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years, except for routine exams or minor illnesses or injuries? *Please document below.*	

Please give details for any positive answers above. _____

_____

_____

Will you be participating on a WFU NCAA athletic team? ☐ Yes ☐ No Which sport? _____

Date: _____

PRINT

Last Name	First Name	Middle Initial	Preferred name	Date of Birth	WFU ID#

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete this form.
THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect his/her status; it will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Health Service and will not be released without student consent. Thank you for your cooperation in completing this form. Please complete the IMMUNIZATION RECORD ON PAGE 4 AND THE TUBERCULOSIS SCREENING QUESTIONNAIRE ON PAGE 5, required by North Carolina Law.

PRINT PAGES 3-5 FOR PHYSICIAN TO COMPLETE

Physical Findings

Height	cm/in
Weight	kg/lb
Pulse	bpm
Blood pressure —systolic	mmHg
—diastolic	mmHg

Was physical examination normal? ____ Yes ____ No

If no, please explain abnormality

Regular medicines - list names and dosages

Disabilities - list

SICKLE CELL SCREEN (IF APPLICABLE): DATE _____ RESULTS _____

Recommendations for physical activity (PE, Intramurals, ROTC) ☐ Unlimited ☐ Limited (*Explain below*)
Do you have any recommendations regarding the care of this student? ☐ No ☐ Yes (*Explain below*)
Is the patient now under treatment for any medical or emotional condition? ☐ No ☐ Yes (*Explain below*)
Have you any general comments? ☐ No ☐ Yes _____

_____

If this student has a disability, food allergy, or condition that requires special housing or meal plan considerations, please forward that information to:
Student Health Service, PO Box 7386, Winston-Salem, NC 27109.

If this student has a disability or condition that requires an academic accommodation, please forward that information to:
Learning Assistance Center, PO Box 7283, Winston-Salem, NC 27109.

Specific information about both of the above may be found at: *http://lac.wfu.edu/files/2011/07/Guidelines-for-Physical-or-Psychiatric-2016.pdf*

PLEASE NOTIFY US OF ANY MEDICAL PROBLEMS THAT DEVELOP AFTER THIS EXAMINATION.

Medical Providers: Please complete the mandatory immunization and TB risk assessment forms on the following 2 pages.

_____ _____
Signature of Physician/Physician Assistant/Nurse Practitioner Date

_____
Print name of Physician/Physician Assistant/Nurse Practitioner

_____ _____
Office Address Area Code/Phone Number

Are you the student's primary care physician? ☐ Yes ☐ No If "no," how long have you known student? _____

PRINT

PRINT PAGE FOR PHYSICIAN TO COMPLETE

In order to attend Wake Forest University, you must comply with North Carolina Immunization requirements, even though your state or country of origin may have different requirements.

1. Have this form completed and signed by your healthcare provider.
2. Mail **or** email this completed form to Wake Forest University Student Health Service: PO Box 7386, Winston Salem, NC 27109; Email: hiif@wfu.edu **DO NOT FAX**

Last Name	First Name	Middle Initial	Preferred name	Date of Birth	WFU ID#

DATE FORMAT: MM/DD/YYYY

DTP-(Diphtheria/ Tetanus/Pertussis): Minimum of 3 doses to include a **Tdap**, with the last dose within the past 10 years

#1_____/_____/_____, **#2** _____/_____/_____, **#3** _____/_____/_____, **#4** _____/_____/_____, **#5** _____/_____/_____

Booster Td _____/_____/_____ **Tdap** _____/_____/_____ **Tdap became available in the US June 2005**

MMR: 2 doses are required.

MMR Dose 1 at age 12-15 months or later _____/_____/_____

MMR Dose 2 at age 4-6 years or later, and at least one month after first dose _____/_____/_____

If given as a single antigen dose, must have 2 Measles, 2 Mumps and 1 Rubella.

Measles _____/_____/_____ **Measles** _____/_____/_____ **Mumps** ____/____/_____ **Mumps** _____/_____/_____ **Rubella** _____/_____/____

(A positive Measles, Mumps, Rubella antibody titer meets the requirement. **Lab report must be attached.**)

Polio (3 doses required for students under 18 years of age)

#1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____ #4_____/_____/_____

Hepatitis B Series: 3 doses are required if born on or after July 1, 1994

#1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____

Minimum 28 days between doses 1 and 2

Minimum 8 weeks between doses 2 and 3

Minimum 16 weeks between doses 1 and 3

Blood titer not accepted as proof of immunization.

Recommended vaccines, but not required:

Meningococcal: Recommended for undergraduates. (If initial dose is given before 16 years of age, booster is necessary.)

#1_____/_____/_____ #2_____/_____/_____

Gardasil OR Cervarix (HPV) #1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____

Hepatitis A #1_____/_____/_____ #2_____/_____/_____

Pneumovax: (for high risk conditions) _____/_____/_____

Varicella #1_____/_____/_____ #2_____/_____/_____

History of Chicken pox Disease _____/_____/_____

Other _____ #1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____ #4_____/_____/_____

Other _____ #1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____

Not required:

Yellow Fever: _____/_____/_____ Typhoid IM _____/_____/_____ Typhoid oral _____/_____/_____

Signature of Healthcare Provider:

Name (print)_____Address/Clinic Stamp_____

Signature:_____Phone (_____)_____

Please see the following page for Tuberculosis Questionnaire information to be completed for ALL students

PRINT

PRINT PAGE FOR PHYSICIAN TO COMPLETE

Wake Forest University Student Health Service Office: (336) 758-5218

Last Name	First Name	Middle Initial	Preferred name	Date of Birth	WFU ID#

Tuberculosis (TB) Screening Questionnaire: All new students are required to complete Sections A and submit this mandatory screening questionnaire along with the completed immunization form. BCG vaccination does not prevent testing. For students who have received the BCG vaccine, an IGRA (blood test) is preferred. If you fail to submit this questionnaire, TB testing will automatically be REQUIRED. Sections B is to be completed by a healthcare provider.

SECTION A: Tuberculosis (TB) Exposure Risk

1.Do any of the following conditions or any of the following situations apply to you?

a) Do you have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? ☐ **YES** ☐ **NO**

b) Have you ever lived with or been in close contact to a person known or suspected of being sick with TB? ☐ **YES** ☐ **NO**

c) Have you ever lived, worked or volunteered in any homeless shelter, prison/jail or long term care facility? ☐ **YES** ☐ **NO**

d)Have you ever been a member of any of the following groups that may have an increase incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, abusing alcohol or drugs? ☐ **YES** ☐ **NO**

2. Have you ever had a BCG vaccine? ☐ **YES** ☐ **NO**

3. Were you born in, or have you lived, worked or visited for > 1 month in one of the following countries listed in the boxes below? ☐ **YES** ☐ **NO**

If YES, where?_____ **How long?**_____

Afghanistan
Albania
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Chad
China
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Ghana
Guatemala
Guam
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
Hungary
India
Indonesia
Iran (Islamic Republic of)
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Taiwan
Tanzania
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

4. Have you ever had a positive Tuberculin Skin Test (TST/PPD) OR positive TB blood test (IGRA)? ☐ **YES** ☐ **NO**

Section B: Tuberculosis (TB) Risk Assessment: (to be completed by a healthcare provider)

Clinicians should review and verify the information above. Persons answering YES to any of the questions in the TB SCREENING are required to have TB testing, [either tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA)], unless a previous positive test has been documented. For previous positive tests, please send test results, CXR results and if applicable, documentation of treatment. ALL NEW TESTING (CXR/TST/IGRA) MUST BE COMPLETED WITHIN THE PAST 6 MONTHS PRECEDING THE FIRST DAY OF CLASSES. IGRA testing is available in the Student Health Service on campus. Anyone with a positive TB Skin test or IGRA with no signs of active disease on chest x-ray should receive recommendation to be treated for latent TB.

Tuberculin Skin Test: Date administered:_____/_____/_____ Date read: _____/_____/_____ Result: _____mm

OR

Tuberculin Blood Test: Date:_____/_____/_____ Result: _____

If TB test is positive: Chest x-ray is REQUIRED: Date done:_____/_____/_____
☐ Normal ☐ Abnormal (must attach radiology report)

Provider Name (print)_____ Address/Clinic stamp_____

Provider Signature:_____ Date: _____

PRINT