Student Health Center
Box 7188
Davidson, N.C. 28035-7188
Phone: 704-894-2300
FAX: 704-894-2615

Medical History and Physical Examination Form

TO ALL NEW STUDENTS ENTERING DAVIDSON COLLEGE

Please complete this required form in its entirety.
It must be received by us no later than **July 15.**

Full Name ______________________________ Nickname ______________________

Expected College Graduation Year ______________ Social Security Number ______________________

Date of Birth (month/day/year) ____________ Sex______ E-mail Address ______________________

Parents' Names ____

Home Address ______________________________ Home Phone (   )________

Parents' Employer ______________________________ Work Phone (   )________

______________________________ Work Phone (   )________

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

NAME OF POLICY HOLDER * SOCIAL SECURITY NO. EMPLOYER

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

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

Does your insurance require primary care physician authorization for referral to specialists? ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN PHONE # FAX #

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY RELATIONSHIP

ADDRESS ______________________________ AREA CODE/TELEPHONE

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**** Please attach a copy of both the front and back of insurance card**.

Return to: Student Health Center, Box 7188, Davidson, N.C. 28035-7188

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT--The immunization requirements must be met or, in accordance with N.C. law, you will be withdrawn from classes without credit.

Acceptable records of your immunizations may be obtained from any of the following: (Be certain that your name and Social Security / 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 year. Keep a copy for your records.)

- High School Records--These may contain some, but not all of your immunization information. Contact Student Health for help if needed.
- Personal Shot Records--Must be certified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department.
- Military Records or WHO (World Health Organization Documents).
- Previous College or University-Your immunization records do not transfer automatically. You must request a copy.

SECTION A:IMMUNIZATION REQUIREMENTS ACCORDING TO AGE

I. STUDENTS 17 YEARS OF AGE OR YOUNGER	II. STUDENTS AGE 18 YEARS OF AGE OR OLDER
Vaccine Required	**Vaccine Required**
3 DTP *(Diphtheria-Tetal1us-Pertussis)* or Td *(Tetanus-Diptheria)* doses. 1 Tdap *(Tetanus-Diphtheria-Pertussis)* dose must be given if a Td has not been given within the last 10 years 3 POLIO (oral) doses 2* MEASLES *(Rubeola)* one dose on or after 12 months of age, the 2nd after 15 months of age. (2 MMR doses meet this requirement.) 1** RUBELLA *(German Measles)* dose. 2** MUMPS	3 DPT *(Diphtheria-Tetal1us-Pertussis)* or Td *(Tetanus-Diphtheria)* doses. 1 Tdap *(Tetanus-Diphtheria-Pertussis) dose must be given if a Td has not been given* within the last 10 years. 2* Measles *(Rubeola)* one dose on or after 12 months of age, the 2nd after 15 months of age. (2MMR doses meet this requirement.) 1** RUBELLA *(German measles)* dose 2** MUMPS
	Tdap vaccine is not required for any student over the age of 64 years.
	Measles and Mumps vaccines are not required if you were born prior to 1957.
	Rubella vaccine is not required if you are age 50 or older.

V. INTERNATIONAL STUDENTS
Vaccine Required
Vaccines are required according to age (refer to appropriate box). Additionally, International students are required to have a TB skin test and negative result within the 12 months preceding the first day of classes (chest x-ray required if test is positive.

* Must repeat Rubeola (measles) vaccine if received even one day 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 disease is acceptable if the vaccine is not taken.

SECTION B: These vaccines are RECOMMENDED. Some may be required by certain departments. Consult your department materials for specific requirements.

SECTION C: These vaccines are OPTIONAL

IMMUNIZATION RECORD *(Please print in black ink)* To be completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.

Last Name	First Name	Middle Name	Date of birth (mo./ day /year)	Social Security Number

SECTION A Required Immunizations	mo. / day! year	mo./aay / year	mo. / day / year	mo. / day / year
• DPT or Td	#1	#2	#3	#4
• Td or Tdap Booster (Please Specify)				
• Polio				
• MMR (After first birthday)				
• MR (After first birthday)				
• Measles (after first birthday)			** Disease Date	**** Titer Date & Result
• Mumps			*** (Disease Date Not Accepted)	**** Titer Date & Result
• Rubella			*** (Disease Date Not Accepted)	**** Titer Date & Result

The following immunizations are not required but are recommended for all students.

• Human Papillomavirus (HPV) Vaccine (female only)	#1	#2	#3	
• Hepatitis B Series	#1	#2	#3	**** Titer Date & Result
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	**** Titer Date & Result
• Meningococcal				
• Tuberculin (PPD) Test (within 12 months) — Date read				
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	#1	#2	
• Typhoid (specify type)			
• Yellow Fever			
Other:			

Signature or Clinic Stamp **REQUIRED**:

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

Print Name of Physician/Physician Assistant/Nurse Practitioner ____________ (Area Code) Phone ( )____________

Office Address ____________ City ____________ State ____________ Zip Code ____________

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** Must repeat Rubeola (measles) vaccine if received even one day 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 physician, is not acceptable.

****Attach a copy of titer report.

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

Last Name (print) First Name Middle Name	Date of birth (mo / day / year)	*Social Security Number

Permanent Address City State Zip Code Area Code/Phone Number

CLASS YOU ARE ENTERING (Circle): FR. SO. JR. SR.

GENDER ☐M ☐ F MARITAL STATUS ☐ S ☐M ☐OTHER

PREVIOUSLY ENROLLED HERE ☐YES ☐ NO

SEMESTER ENTERING (circle) FALL SPRING YEAR

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 explanation.*

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

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

	Yes	No	Relationship
High Blood pressure Stroke			
Stroke			
Cancer			
Heart attack before age 55			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Blood or clotting disorder			
Alcohol/Drug problems			
Psychiatric illness			
Suicide			

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/pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Tuberculosis			
Tumor / cancer (.specify)			
Malaria			
Thyroid trouble			
Serious skin disease			
Alcohol/drug problem			
Sexually transmitted disease			
Sleep problems			

	Yes	No	Year
Mononucleosis			
Hay fever			
Head/neck radiation treat.			
Arthritis			
Concussion			
Frequent/ se\'ere headache			
Dizziness/ fainting spells			
Severe head injury			
Paralysis			
Epilepsy /Seizures			
Disabling Depression			
Anxiety / panic			
Ulcer (duodenal/stomach)			
Intestinal trouble			
Pilonidal cyst			
LD/ADD/ADHD			

	Yes	No	Year
Self-induced vomiting			
Frequent vomiting			
Gall bladder or gallstones			
Jaundice or Hepatitis			
Rectal disease			
Severe/ recurrent abdom. pain			
Hernia			
Chicken pox			
Anemia/Sickle Cell Anemia			
Eye trouble besides glasses			
Bone, joint, other deformity			
Shoulder dislocation			
Knee problems			
Recurrent back pain			
Neck injury			
Self-injurious behavior			

	Yes	No	Year
Back injury			
Broken bones			
Kidney infection			
Bladder infection			
Kidney stone			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Blood transfusion			
Smoke 1 + packs ag. / week			
Diabetes			
Eating Disorder			
Allergy injection therapy			
Obsessive compulsive			

☐ I would like for someone from the Counseling Center to contact me about mental health resources on campus.

Please describe any conditions or disabilities that would exclude participation in physical education. ______________________________

Do you exercise three or more times per week? ☐ YES ☐ NO Do you use a seatbelt on a regular basis? ☐ YES ☐NO

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

Name Use Dosage Name Use Dosage

Name Use Dosage Name Use Dosage

Name Use Dosage Name Use Dosage

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PERSONAL HEALTH HISTORY-CONTINUED *(Please print in black ink)* To be completed by student.

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). Have you ever experienced adverse reactions (hypersensitivity, 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 Reaction to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

Do you have any condition or disability that limits 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 a routine checkup, 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 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 permitted by law. If I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission for Student Health Services to release information from my (son/daughter's) medical record to a physician, hospital, or other medical personnel 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 Center.

(C) I am aware that the health center charges for some services and I will be billed through the Business Services Office. 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 college is unaffected by the existence of insurance coverage.

(D) If I have elected coverage under the college health insurance policy, I hereby authorize the release of medical information necessary to process insurance claims and authorize Markel Insurance Company or their representatives to pay benefits directly to the Student Health Center for services received.

______________________________ ______________________

Signature of Student
and Parent/Guardian

Date

PHYSICAL EXAMINATION ***(Please print in black ink)*** To be completed and signed by physician or clinic. A physical examination is required within the past year. Please complete in its entirety.

Last Name First Name Middle Name	Date of birth (mo / day / year)	*Social Security Number

Permanent Address City State Zip Code Area Code/Phone Number

Height ________________Weight _________ TPR _________/ _________/ ______ BP _________ / _________

Vision: Corrected Right 20/ __________ Left 20/________
Uncorrected Right 20/ ___________ Left 20/ ______
Color Vision ___________________________

Hearing: (gross) Right ________ Left ________
15 ft / Right ________ Left __________

Urinalysis: Sugar: _________ Albumin___________
Micro __________
Hgb or Hct ____
STS (If indicated) ___________________________________
Date_________________ Result___________________
Recommendations______________________________

Are there abnormalities? If so, describe in full	YES	NO	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic / Endocrine			
10. Neuropsvchiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? □Yes □No
Explain____

B. Is student under treatment for any medical or mental health condition? □Yes □No
Explain ____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited_____________ Limited_____________

____ ____________________
Signature of Physician / Physician Assistant / Nurse Practitioner Date

____ ______(______)__________
Print Name of Physician/Physician Assistant/Nurse Practitioner (Area Code) Phone

____
Office Address City State Zip Code

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