STUDENT HEALTH SERVICES
MEDICAL FORMS

Dear Student,
Congratulations on your acceptance to Brevard College!

The following forms **must** be submitted before your arrival in August:
Completed immunization record *and* ***Medical History Form.***

The Medical History Form does not require a physician's signature.

North Carolina state law (N.C. G.S. §130A-155.1) mandates all students attending college must submit a completed immunization record to the college. This includes students that live on campus, as well as off campus students taking 5 credit hours or more per semester. ***Students not meeting these requirements must be immunized during the initial 30 days of the semester or be removed from the College.*** The only exemptions allowed by law are for students with a religious or medical exemption. You can find more information (*exact vaccinations required, exemption rules, etc.*): https://www.immunize.nc.gov/schools/collegesuniversities.htm

Guidelines for Completing Immunization Requirement:

1. All immunizations must include **month/date/year** for each vaccination.

2. If you do not currently have a copy of your records you can request a copy from your state immunization registry. These can be requested online. You will need to Google search 'State Immunization Registry' in your state and complete their instructions. Your physician's office or local health department may also supply a record for you.

3. **International students** must have a negative TB skin or blood test within 6 months prior to arriving on campus.

4. **Athletes** do not give coaches or trainers your immunization forms.

Send your completed forms to:
- immunizations@brevard.edu
- Via fax to 828.884.8293
- Via mail to Stamey Student Health Center, 1 Brevard College Dr., Brevard, NC 28712

QUESTIONS:
immunizations@brevard.edu
Margaret Dellinger 828.884.8246

MEDICAL HISTORY FORM

TO THE STUDENT: The information which you provide will be used as an aid in administering any necessary care while you are a student at Brevard College. All students' medical records are kept in the clinic and are confidential.

If you have medical, emotional, physical, or learning challenges, you MAY want to contact the Office of Student Accessibility & Disability Services at 828-884-8131

Please complete all items on this form. *Please print or type.*

Last Name	First Name	Middle	Student ID Number
Home Address (No. and Street)	City	State ZIP	Phone

Date of Birth _____ Sex: □ M □ F Marital Status: □ S □ M □ D

Entering: □ Fall _____ □ Spring _____ □ Summer _____ Previously Enrolled? □ Yes □ No When? _____

REPORT OF MEDICAL HISTORY

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

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

	Yes	No	Relationship
High Blood Pressure			
Stroke			
Cancer type:			
Heart attack before 55			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Blood or clotting disorder			
Alcohol 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, Murmur or Arrhythmia			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Tuberculosis			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Serious skin disease			
Alcohol/drug use			
Smoke 1+ pack cigarettes/week			

	Yes	No	Year
Mononucleosis			
Hay fever			
Head or neck radiation treatments			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Epilepsy/Seizures			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Anorexia/Bulimia			

	Yes	No	Year
Self-induced vomiting			
Frequent vomiting			
Gall bladder trouble or gallstones			
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Blood transfusion			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint or other deformity			
Shoulder dislocation			
Knee problems			
Recurrent back pain			
Neck injury			

	Yes	No	Year
Back injury			
Broken bones			
Kidney infection			
Bladder infection			
Kidney stone			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Diabetes			
Male: Loss of testicle or other issues			
Female: Irregular or painful periods			
Severe menstrual cramps			
Sexually Transmitted Disease			
Chronic Fatigue or Fibromyalgia			
Allergy injection therapy			

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

Name _____ Dosage _____ Use _____

Name _____ Dosage _____ Use _____

Name _____ Dosage _____ Use _____

Name _____ Dosage _____ Use _____

DO YOU REQUIRE AN EPI-PEN (or other device) FOR ALLERGIC REACTIONS? □ Yes □ No

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 (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.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Animals			
Latex			
Food allergies (name)			
	Yes	**No**	**Explanation**
Have you ever been a patient in any type of hospital? (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 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.)			

Personal History:	**Yes No**	**Chest/Heart/Lungs:**	**Yes No**		**Yes No**
Lost weight in last year?		Shortness of Breath		Chest Pain or Pressure	
On a special diet?		Back Pain		Frequent Cough	
Satisfied w/ weight?		Knee Pain		Wheezing	
Difficulty sleeping?		Abnormal Heart Rate			

Injury History/PMH: Have you ever injured or had a problem with: If multiple, give most recent

		Yes	No	
Neck				If yes, when? Date: _____
Shoulder	R L			If yes, when? Date: _____
Elbow	R L			If yes, when? Date: _____
Wrist/Hand/Finger	R L			If yes, when? Date: _____
Back				If yes, when? Date: _____
Hip	R L			If yes, when? Date: _____
Knee	R L			If yes, when? Date: _____
Ankle/Foot/Toes	R L			If yes, when? Date: _____
Broken Bone				If yes, when? Date: _____

I, _____ (Print Name) the undersigned, herewith:

A) Understand that I must refrain from physical activities, practice or play while ill or injured, whether or not receiving medical treatment, until discharged from treatment or given permission by the clinical practitioner to restart participation, despite continuing treatment.
B) Understand that having passed the physical examination does not necessarily mean that I am physically qualified to engage in physical activity and/or athletics, but only that the examiner did not find a medical reason to disqualify at the time of said examination.
C) Give permission to the BC Medical Staff and Medical Doctors involved in my care to discuss medical conditions pertaining to said care in regards to physical activity and/or athletic participation.

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 understand that the information is strictly confidential and will not be released to anyone without my written consent unless by Court order. However, if I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission for Student Health Services or Athletic Training Department to release information from my medical record to a physician, hospital, or other medical agency involved in providing me with emergency treatment and/or medical care.

Student Signature: _____ Date: _____

Print Name: _____

Parent/Guardian Signature: _____ Date: _____
(**only for students under 18 years of age**)

Please read the following information about Meningococcal Disease:
Certain college students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. College freshmen, particularly those living in dormitories or residence halls, are at a modestly increased risk for meningococcal disease compared with persons the same age that are not attending college.
What is meningococcal meningitis? Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling fluid surrounding the brain and spinal column as well as sever and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.
How is it spread? Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.
What are the symptoms? Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.
Who is at risk? Certain college students, particularly freshmen who live in dormitories or residence halls, have been found to have an increased risk for meningococcal meningitis. Other undergraduates can also consider vaccination to reduce their risk for the disease.
Can meningitis be prevented? Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease. The vaccine provides protection for approximately three to five years. As with any vaccine, vaccination against meningitis may not protect 10 percent of all susceptible individuals.
For more information: Visit the website of the Centers of Disease Control and Prevention (CDC) at: www.cdc.gov/ncidod/dbmd/diseaseinfo or at www.cdc.gov/nip/publications/ACIP-list.htm. Or visit the website of the American College Health Association, www.acha.org. To obtain the vaccination, contact your personal physician or local health department (828.884.31135).

STATEMENT BY STUDENT (A PARENT OR GUARDIAN MUST ALSO SIGN IF A STUDENT IS UNDER AGE 18, OR STUDENT IS A RESIDENT OF ALABAMA AND UNDER AGE 19, OR IS STUDENT IS A RESIDENT OF MISSISSIPPI AND UNDER AGE 21):
I have personal supplied (or reviewed) the information on this three page history and attest that it is true and complete to the best of my knowledge. I understand that the information strictly confidential but may be shared with those on a need to know basis or by Court Order. If I (my child) should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to Brevard College to release information form my son's/daughter's medic al records (this form and other medical forms) to a physician, hospital, or other medical agency involved in providing me (him/her) with emergency treatment and /or medical care. I authorize copies of my (the student's) medical record to be released to the athletic, physical education, outdoor education and environmental departments, in accordance with requirements from those departments.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian Date