Memorandum

To: Directors of Special Programs for Summer Sessions

From: Dr. David Wagner, III
       Director of Student Health Center

DATE: September 9, 2015

REF: Health Services

Please note the following pertinent information for all applicants attending special programs during the summer session at North Carolina A & T State University.

1. Directors of Special Programs should submit a roster of their program’s applicants to Bettye Young-Stewart, Summer Program Coordinator, at the Student Health Center. The Business Office Manager will return an invoice to each department with a charge of $45.00 per applicant.

2. Medical History Forms will be forwarded to each Special Program’s Director to be sent to parents of applicants. Parents must sign the form giving their permission for treatment and return the child’s updated immunization record with the medical history to the program director. Should any applicant need an MMR or Tetanus vaccine, they may be obtained at the Student Center for a nominal fee $63-$78 per vaccine. Students under the age of 18 must bring written permission from a parent or guardian in order to receive medical treatment or to receive vaccines.

3. Those departments that choose not to pay in advance for program applicants will be charged a consultation fee of $25.00 and any other additional fees such as laboratory test and/or medications prescribed by the physician. However, the Student Health Center personnel cannot administer treatment to any student under the age of 18 without signed parental consent.

Should you need additional information concerning this matter, please contact Bettye Young-Stewart at 336-285-2930.
PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below or on additional sheet.

<table>
<thead>
<tr>
<th>HAVE YOU HAD</th>
<th>Yes</th>
<th>No</th>
<th>HAVE YOU HAD</th>
<th>Yes</th>
<th>No</th>
<th>HAVE YOU HAD</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Trouble</td>
<td></td>
<td></td>
<td>Frequent or Severe</td>
<td></td>
<td></td>
<td>Kidney or Bladder Dise.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear, Nose Throat Trouble</td>
<td></td>
<td></td>
<td>Respiratory Infections</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent or Severe Headaches</td>
<td></td>
<td></td>
<td>Rheumatic Fever or Heart Murmur</td>
<td></td>
<td></td>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td>Stomach or Intestinal Tro.</td>
<td></td>
<td></td>
<td>Irregular Periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma, Hay Fever, Hives</td>
<td></td>
<td></td>
<td>Infect. Mononucleosis</td>
<td></td>
<td></td>
<td>Severe Cramps</td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td>Hepatitis or Jaundice</td>
<td></td>
<td></td>
<td>Excessive Flow</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(GIVE DETAILS IF NEEDED)

A. Do you have any disease, or is any drug other treatment being followed, which should be continued or periodically evaluated (Details)

B. Have you any drug allergy or other known sensitivity or intolerance? (Details)

C. Have you had any illness, injury, or operation or been hospitalized other than as already noted? (Explained)

D. Has your physical activity been restricted during the past five years? (Explain)

E. Have you ever been hospitalized for mental or emotional illness? (Explain)

F. Have you ever interrupted school or work because of mental or emotional illness or after psychiatric consultation?

STATEMENT BY STUDENT 18 YEARS OF AGE & OLDER: I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I hereby give my permission to any doctor, hospital or other medical agency to release confidentially to the Student Health Service Physician(s) of A&T State University any information they may have concerning my medical condition and their professional contact with me. A photocopy of this permission is to be considered as valid as original.

Signature of Student Date
### IMMUNIZATION RECORD

**Last Name**  | **First Name**  | **Middle Name**  | **Date of Birth (mo./day/year)**  | **Gender**
--- | --- | --- | --- | ---

**Parents Name:**

**Home Address**

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

### SECTION A REQUIRED IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Dose</th>
<th>Disease Date</th>
<th>Titer Date &amp; Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP, DTaP, TD, or Tdap</td>
<td>(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap Booster (If due update after 7/2008)</td>
<td>(2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Td Booster</td>
<td>(3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>(4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR (2 doses after 1st birthday)</td>
<td></td>
<td><strong>(Disease Date)</strong></td>
<td></td>
</tr>
<tr>
<td>Measles / Rubella (MR) (after first birthday)</td>
<td></td>
<td><strong>Titer Date &amp; Result</strong></td>
<td></td>
</tr>
<tr>
<td>Measles (2 doses after 1st birthday)</td>
<td></td>
<td><strong>(Disease Date NOT Accepted)</strong></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td><strong>(Disease Date NOT Accepted)</strong></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td><strong>(Disease Date NOT Accepted)</strong></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B (required if born 7/1/94 or after)</td>
<td>(1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### International Student Requirements:

- Tuberculin (PPD) Test Date Given
  - (within 12 months)
  - Date Read
  - mm in duration
- Chest X-ray, if positive PPD Date
- (Report result in mm induration) Result
- Treatment if applicable Date

### SECTION B RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain colleges of 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:
  - Hepatitis B series only
  - Hepatitis A/B combination series

**Varicella (chicken pox) series of two doses or immunity by positive blood titer**

### SECTION C OPTIONAL IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date Of Test: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemophilus influenza type b</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A series only</td>
<td></td>
</tr>
<tr>
<td>Typhoid</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
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<tr>
<td>HPV (Gardasil)</td>
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<tr>
<td>Other</td>
<td></td>
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</table>

### SECTION D SICKLE CELL

**Results:**

- Positive ___ / Negative ___
- Trait ________

***Laboratory proof of Sickle Cell testing must be attached to records***

**Signature or Clinic Stamp REQUIRED:**

**Signature of Physician/Physician Assistant/Nurse Practitioner**

**Date**

**Print Name of Physician/Physician Assistant/Nurse Practitioner**

**Office Address**  | **City**  | **State**  | **Zip Code**
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**Rev 08/08; 11/10; 1/11**

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**Must repeat Rubella (measles) vaccine if received even 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.
Consent for Treatment of Student’s Under 17-Years-Old

I have reviewed the submitted health and immunization history and attest that the information is true to my knowledge. I understand that the information is strictly confidential and will not be released without my consent, unless otherwise permitted by law.

If my son/daughter is unable to sign the appropriate form(s), I hereby give my permission to the institution to release information from my (son/daughter) medical record to a physician, hospital, or other medical professional involved in providing emergency treatment and/or medical care.

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 payment of incurred charges.

I hereby authorize any medical treatment for my (son/daughter) that may be advised or recommended by the NC A&T SU Student Health Center clinical staff.

______________________________________________
Student Name (please print)

______________________________________________
NCA&T SU Banner ID# (please print)

______________________________________________
Signature of Parent

______________________________________________
Print Name of Parent

______________________________________________
Relationship to Student