NORTH CAROLINA
AGRICULTURAL AND TECHNICAL
STATE UNIVERSITY

www.ncat.edu

A LAND-GRANT UNIVERSITY *and* A CONSTITUENT INSTITUTION *of* THE UNIVERSITY *of* NORTH CAROLINA

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 336-285-285-2930.

Division of Student Affairs | Student Health Center | 1601 East Market Street, Greensboro, NC 27411 | Office 336.334.7880 Fax 336.334.7264

North Carolina A &T State University
STUDENT HEALTH SERVICE
Greensboro, NC 27411
336-334-7880 (Office) 336-256-2613 (Fax)

REPORT OF MEDICAL HISTORY
(Summer Outreach)

** Provision of Social Security number is voluntary and is requested solely for administrative convenience, record keeping accuracy, and to provide a personal identifier for the internal records of this institution.

LAST NAME (PRINT) FIRST NAME MIDDLE **BANNER ID#

HOME ADDRESS (NUMBER & STREET) CITY STATE ZIP TELEPHONE #

DATE OF BIRTH: SEX M ☐ F ☐ MARITAL STATUS S M OTHER

Fr. Soph. Jr. Sr. Grad. Yes ☐ No ☐ SUMMER I ☐ II ☐ DUAL ☐ 20____

CLASS YOU ARE ENTERING (Circle) PREVIOUSLY ENROLLED HERE? REGISTRATION DATE:

HOSPITAL HEALTH INSURANCE/ NAME OF COMPANY ADDRESS POLICY #

NAME & RELATIONSHIP OF NEXT OF KIN ADDRES TELEPHONE #

PARENTS OF STUDENTS UNDER 18: I hereby authorize any medical treatment for my son / daughter which may be a advised or recommended by the medical staff of the Student Health Service of the N C A&T State University at Greensboro, NC.

________________________________ __________________

Signature of Parent Guardian Date

PERSONAL HISTORY PLEASE ANSWER ALL QUESTIONS Comment on all positive answers in space below or on additional sheet.

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

(GIVE DETAILS IF NEEDED)	YES	NO	Remarks Additional Information
A. Do you have any disease, or is any drug other treatment being followed, which should be continued or periodally evaluated (Details)			
B. Have you any drug allergy or other know 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.

Have Any of your Relatives Had Any of the Following?	Yes	No	Relationship
Tuberculosis			
Diabetes			
Heart Disease			
Kidney Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

________________________________ ______________

Signature of Student Date

Rev 4/07; 02/12

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

	mo./day/year	mo./day/year	mo./day/year	mo.day/day/year
• DTP, DTaP,TD, or Tdap	(#1)	(#2)	(#3)	(#4)
• **Tdap Booster (If due update after 7/2008)**				
• Td Booster				
• Polio				
• MMR (2 doses after 1st birthday)				
• Measles / Rubella (MR) (after first birthday)				
• Measles (2 doses after 1st birthday)			**Disease Date	****Titer Date& Result
• Mumps			**(Disease Date NOT Accepted)	****Titer Date& Result
• Rubella			**(Disease Date NOT Accepted)	****Titer Date& Result
• Hepatitis B (required if born 7/1/94 or after)	(#1)	(#2)	(#3)	

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:

	mo./day/year	mo./day/year	mo./day/year	
• Hepatitis B series only **OR**				****Titer Date& Result
• Hepatitis A/B combination series				
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date& Result

SECTION C OPTIONAL IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year
• Haemophilus influenza type b			
• Pneumococcal			
• Hepatitis A series only			
• Typhoid			
• Influenza			
• HPV (Gardasil)			
• Other			

SECTION D SICKLE CELL

Date Of Test:____/____/____

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 — Area Code/Phone Number

Office Address — City — State — Zip Code

** 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.**

NORTH CAROLINA
AGRICULTURAL AND TECHNICAL
STATE UNIVERSITY

www.ncat.edu

A LAND-GRANT UNIVERSITY *and* A CONSTITUENT INSTITUTION *of* THE UNIVERSITY *of* NORTH CAROLINA

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

Division of Student Affairs
Student Health Center
1601 East Market Street
Greensboro, NC 27411
Office 336.334.7880
Fax 336.334.7264