CATAWBA COLLEGE

To: New Students and Parents or Legal Guardians

From: Catawba College Proctor Foundation Health Services Center
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Welcome and congratulations on your acceptance to Catawba College. We look forward to meeting you and managing your health care while you are a student on our campus. Catawba College is interested in every phase of student life. An active Health Services Center is available and every effort is made to provide excellent health care. Some of our services are:

1. Management of acute problems by nurses in the Center, with easy access to physician by telephone.
2. Over the counter medication given at NO cost.
3. Laboratory testing, when ordered by physician, billed to your insurance company.

The Health Services Center is open Monday through Friday from 8 a.m. - 4:30 p.m.

Coverage on the weekends is handled by Rowan Regional Medical Center, the regional hospital, Pro-Med, and Romedical Center, walk-in clinics. There will be a charge for services rendered at either of these facilities which are located in Salisbury.

Attached, please find the Catawba College health form which **MUST** be completed 30 days prior to enrollment. Note that one side of the form (Health History) is to be completed by the student. The reverse side (Physical Examination and Immunization) **MUST BE COMPLETED BY A PHYSICIAN.**

PLEASE REMEMBER TO SEND A COPY OF YOUR INSURANCE CARD. If you have HMO insurance, please contact your primary physician before arriving to start classes at Catawba.

Return this form and a copy of your insurance card **NO LATER THAN 30 DAYS PRIOR TO ENROLLMENT** to:

Proctor Foundation Health Services Center
Catawba College
2300 West Innes Street
Salisbury, NC 28144-2488

It is required by North Carolina State Law (General Statutes 130A-157, as amended effective July 1, 1994) that this form be on file at the Health Services Center **BEFORE** registration. **Students not satisfactorily meeting immunization requirements will be subject to suspension from Catawba College.**

DO NOT MAIL UNTIL ALL PROCEDURES ARE COMPLETED AND ENTERED ON THIS FORM.

December 2000

THIS FORM MUST BE COMPLETED AND RETURNED NO LATER THAN 30 DAYS PRIOR TO ENROLLMENT.

Catawba College
Health History
to be completed by Student

For Office Use Only
completed _____
letter _____
vaccine required_____
computer _____

Please answer all questions. *Print or type*

Name ______________________________________ Sex ______ Age __________ Birth Date _______________
Last First Middle

Home Address ______________________________________ Phone ________________________________
Street City State Zip

Marital Status: S M W D Social Security Number ____________________________ Student's Cell Number __________________________

HOSPITAL/ HEALTH INSURANCE: THIS MUST BE COMPLETED. Must make copy of card (Front and Back) and enclose.

Subscriber's ID ______________________ Group No. _____________________ Subscriber's Name _________________________________

____
Name of Company Address Phone Number

Is your Insurance an HMO? ☐ yes ☐ no; If yes, Name of Physician ______________________________________
Name Address Phone Number

* **Insurance Coverage Mandatory** Personal_______ School______

CLASS YOU ARE ENTERING	PREVIOUSLY ENROLLED	PROPOSED REGISTRATION
☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior	☐ No ☐ Yes Date (s) ________	☐ Fall ☐ Spring ☐ Summer 20____

PERSONAL HISTORY: In order to better facilitate student care, please answer if you have ever had any of the following:

	yes	no		yes	no		yes	no
Arthritis			Rheumatic Fever			Ear, Nose, Throat Trouble		
Migraine			Heart Disease or Mumur			Anorexia Nervosa/ Bulimia		
Epilepsy (convulsive disorder)			High Blood Pressure			Hepatitis		
Asthma, Hayfever, Hives			Tuberculosis			Kidney Disease		
Other Allergic Conditions			Diabetes			Gastrointestinal Conditions		
Mononucleosis			Emotional Condition			Learning Disability		

Other serious illnesses/ hospitalizations/ injuries/ disabilities/ deformities: ______________________

If any of the above are YES, give details: ______________________

____

Any medical condition which will interfere with regular physical education or athletic participation? ______________________

If so, what? ______________________

Give name(s) and address(es) of doctor(s) and/ or hospital(s) or clinic(s): ______________________

____

Any emotional condition, give name(s) and address(es) of doctor(s) and/ or hospital(s) or clinic(s): ______________________

____

PRESENT ILLNESS: Any disease, drug or treatment that should be continued or evaluated periodically? ☐ yes ☐ no

If yes, please explain: ______________________

DRUG SENSITIVITY: ☐ yes ☐ no If yes, what drugs? ______________________

EMERGENCY INFORMATION: In case of emergency, please notify: ______________________
Name Address

Relationship _________________________ Phone ______________________________________ Email ______________________

PARENT/ GUARDIAN of students under 18: I hereby authorize any medical treatment for my child which may be advised or recommended by the medical staff of the Catawba College Student Health Center.

Signature of Parent/ Guardian: ____ Date ______________________

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 hereby give my permission to any doctor, hospital, or other medical agency to release confidentially to the Student Health Center Physician(s) of Catawba College any information they may have concerning my medical condition and their professional contact with me.

Signature of Student: ____ Date ________________________________

Name ________________

Proctor Student Health Center: Catawba College
IMMUNIZATION HISTORY- Part I
A - G Mandatory

N.C. STATE LAW REQUIRES THAT ANY STUDENT NOT PRESENTING PHYSICIAN-SIGNED IMMUNIZATION MUST BE IMMUNIZED DURING THE INITIAL 30 DAY OF THE SEMESTER. NON-COMPLIANCE REQUIRES REMOVAL FROM SCHOOL. COPIES OF THE N.C. HIGH SCHOOL IMMUNIZATION CERTIFICATION OR OFFICIAL DOCUMENTATION ARE ACCEPTABLE IF UP-TO-DATE.

A. TETANUS-DIPHTHERIA

Tetanus-Pertussis-Diphtheria **SERIES OF THREE DATES:** (MO) (DAY) (YR) (MO) (DAY) (YR) (MO) (DAY) (YR)

-AND-

Tetanus-Diphtheria-Booster **WITHIN PAST 10 YEARS** **Date of Vaccination:** (MO) (DAY) (YR)

B. MEASLES, MUMPS, RUBELLA (MMR) - TWO DOSES REQUIRED

Dose 1 - At least one month after 1st birthday **Date of Vaccination:** (MO) (DAY) (YR)

-AND-

Dose 2 - At least one month after 1st dose **Date of Vaccination:** (MO) (DAY) (YR)

IF MMR NOT GIVEN, PROCEED TO C, D AND E.

C. MEASLES (RUBEOLA) Check one (not required if born before 1/1/57)

1. Two does required **Date of Vaccination:** (MO) (DAY) (YR)

Dose 1-Immunization on or after 1st birthday

-AND- **Date of Vaccination:** (MO) (DAY) (YR)

Dose 2-At least one month after 1st dose

Date of Disease: (MO) (DAY) (YR)

2. Had disease; confirmed by office record

-OR- **Date of Titer:** (MO) (DAY) (YR)

3. Report of positive immune titer

D. RUBELLA - History of disease is NOT acceptable verification. Check one (not required if 50 years old or older) **Date of Vaccination:** (MO) (DAY) (YR)

1. Immunization on or after 1st birthday

-OR- **Date:** (MO) (DAY) (YR)

2. Has report of positive immune titer

E. MUMPS - Check one (not required if born before 1/1/57) **Date of Vaccination:** (MO) (DAY) (YR)

1. Immunization on or after 1st birthday

-OR- **Date of Disease:** (MO) (DAY) (YR)

2. Had disease; confirmed by office record

F. POLIO - **Last Booster Date:** (MO) (DAY) (YR)

1. Completed primary series ☐ no ☐ yes; Type of vaccine ☐ OPV ☐ IPV

G. Tuberculin/ REQUIRED by Catawba College

Tuberculin skin test within a year of registration date **(MUST HAVE RESULT)** Result ________ **Date:** (MO) (DAY) (YR)

IMMUNIZATION HISTORY- Part II

If student is known to be tuberculin positive or if this test result is positive, attach record of treatment/ Chest X-Ray

Hepatitis B (series of 3) Dates: #1__________ #2 __________ #3 __________
(recommended, not mandatory)

Meningitis Vaccine Date: ____________
(recommended, not mandatory)

PHYSICIAN'S NAME (Print or Type) ______________________ Physician's Signature ______________________

ADDRESS Street Address ______________ City ______________ State ______________ Zip ______________

PHONE NUMBER______________________________ **DATE** ______________________

PLEASE MAIL COMPLETED FORM 30 DAYS PRIOR TO ENROLLMENT.

PHYSICAL EXAMINATION

Must be completed by Physician

NOTE: The student shall have a physical examination within the TWELVE (12) month period preceding date of entrance to Catawba. Students participating in VARSITY athletics MUST HAVE the physical examination within the three (3) month period preceding date of entrance to Catawba. Information on this form will be made available to college officials as deemed necessary for the student's well-being.

Name ______________________________ Date of Birth ____________ Sport(s) ____________

Weight ______________ Height __________ Sex ________ Blood Pressure ____________ Pulse ____________

Eyes: Vision Right-- 20/___ Left-- 20/___ Corrected to Right-- 20/___ Left-- 20/___

	Normal	Describe Abnormality		Normal	Describe Abnormality
Head, Nose, Ears, Neck			Hernia		
Respiratory			Genitourinary		
Cardiovascular			Musculoskeletal		
Metabolic/ Endocrine			Skin		
Gastrointestinal			Emotional Disorders		

ALL CATAWBA STUDENT-ATHLETES must show proof of Sickle Cell Testing via an attached physician's note!

Sickle Cell Postive: _____Yes _____No Sickle Cell Trait: _____Yes _____No Student-Athlete refused tesing: _____Yes _____No

Is there loss or seriously impaired function of any organ? ____________ Comment(s) ____________

Remarks pertinent to history or physical ____________

Urinalysis:

Glucose ______________ Albumin ______________ Microscopic ____________

Is student under treatment for any medical or emotional condition? ☐ Yes ☐ No Capable of unlimited athletic participation? ☐ Yes ☐ No

Recommendations or comments: ____________

Please list all medications, dosage, and frequency:

Medications: ______________ Dosage:______________ Frequency:______________

Medications: ______________ Dosage:______________ Frequency:______________

Medications: ______________ Dosage:______________ Frequency:______________

Medications: ______________ Dosage:______________ Frequency:______________

Medications: ______________ Dosage:______________ Frequency:______________

Medications: ______________ Dosage:______________ Frequency:______________

Medications: ______________ Dosage:______________ Frequency:______________

Medications: ______________ Dosage:______________ Frequency:______________

Medications: ______________ Dosage:______________ Frequency:______________

Medications: ______________ Dosage:______________ Frequency:______________

Signed ______________________________, M.D. (Print Name) ______________________________M.D.

Address and telephone of M.D. (please print)

Date of exam ______________________________