UNIVERSITY OF NORTH CAROLINA WILMINGTON
ABRONS STUDENT HEALTH CENTER

PRIOR TO ORIENTATION
Send completed health forms via mail or fax to:

University of North Carolina Wilmington
Abrons Student Health Center
601 S. College Road
DePaolo Hall, 2nd Floor
Wilmington, NC 28403

Email: immunizations@uncw.edu
Fax: 910-962-4130

If you have questions, call Student Health: 910-962-3280
UNIVERSITY OF NORTH CAROLINA WILMINGTON ABRONS STUDENT HEALTH CENTER
IMPORTANT GUIDELINES FOR Completing REQUIRED HEALTH INFORMATION

IMMUNIZATIONS - Your immunization records do not transfer automatically from high schools or other colleges/universities, you must request them
• Acceptable immunization records may be obtained from any of the following but may not contain all requirements:
  • Personal Shot Record from your Physician (must be verified by a doctor’s stamp or provider signature or clinic stamp
  • Permanent School Health/Medical Record - NO transcripts
  • Local Health Department Immunization Record
  • Previous College or University Immunization Record
  • Military Records or World Health Organization (WHO) Documents
• You may submit immunizations from the sources above or have your health care provider complete and sign the Immunization Certificate/Record. You may not submit the immunization certificate/record without a health care provider’s signature.
• You may review immunization requirements on the immunization requirements or at the North Carolina Immunization Branch: http://www.immunize.nc.gov/schools/collegesuniversities.htm

**Please attach any official, legible immunization records that provide documentation making sure that your name and date of birth are on all pages. All documents must be in English. Keep a copy of records for yourself.

IMPORTANT – Immunization requirements must be met within 30 days from the date of registration, or you will be withdrawn from your classes by the Registrar without receiving course credit or monetary refund for classes.

REPORT OF MEDICAL HISTORY
Students should complete and sign the report. If a student is under 18, the student should complete the form and sign as well as a parent or guardian must sign the form.

PHYSICAL EXAMINATION
A physical examination is not required for admission to the University. If a student is taking a physical education course and has a medical condition that may affect participation, the course instructor will request documentation of a physical within the past 14 months or require the student to get a physical.

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Email: immunizations@uncw.edu

HEALTH INSURANCE
Students are required to WAIVE or ENROLL the student health insurance online through the webportal each semester:
• Undergraduate (not enrolled in Distance Education courses) enrolled in a minimum of 6 semester credit hours and Graduate students (not enrolled in Distance Education courses) enrolled in a minimum of 1 semester credit hour, AND
• Enrolled in a degree-seeking program, AND
• Eligible to pay the university Student Health Services Fee (which is part of tuition)

Visit the web portal: http://studentbluenc.com/#/uncw and follow these steps carefully:
Step 1: Register to create an account. Then login using your account user name and password.
Step 2: Have your UNCW student ID # that begins with 850.
Use your UNCW email address as the primary email address. Include a parent’s email address as the secondary email so everyone receives updates.
If waiving, have your insurance card (front/back).
If enrolling, have the address where you want your insurance benefits/card sent.
Step 3: Check your UNCW email to verify your waiver status.
Step 4: Check your student account/bill to verify the health insurance charge was placed on your account or you have a credit for waiving.

Insurance Questions? Contact StudentBlue (BCBS of NC) at 1-888-351-8283 or Student Health at 910-962-3280

IMPORTANT – Insurance information you provide on the medical history, to housing, to athletics or any other entity on campus is NOT entered into the web portal and is NOT considered a waiver.
UNIVERSITY OF NORTH CAROLINA WILMINGTON ABRONS STUDENT HEALTH CENTER
IMMUNIZATION REQUIREMENTS

All students are required to submit immunizations under North Carolina Law unless:
Students reside off campus and are registered for any combination of:
- No more than four traditional day credit
  hours in on-campus courses
- Off campus courses

- Evening courses (start at 5:00PM or later)
- Weekend courses

- Your immunization records do not transfer automatically from high schools or other colleges/universities. You must request them to be sent to the Student Health Center.

  *Immunizations must be in compliance no later than 30 days upon registering for classes. You will be withdrawn from your classes by the Registrar if you fail to meet the immunization requirements.

| Have your physician enter information on Immunization Certificate/Record and sign
  or Provide adequate, legible documents.
  Submit immunizations in English by mm/dd/yyyy
|

DTP & Tdap – minimum 3 doses
Childhood DTP series, *Not required if proof is provided of entry to college/university prior to 07/01/2008
Tdap (must have received 1 dose), *Must be current with Tdap or Td, given in the past 10 years

HEPATITIS B – 3 doses
Hepatitis A/B series is acceptable, *Not required if born before 07/01/1994
Titers not accepted

MMR – 2 doses
1st dose must be given on or after 12 months of age
If given separately, document individually in the appropriate block
Measles
  *Not required if disease prior to 01/01/1994 or born before 1957
  *2nd dose not required if entered school or in college/university before 07/01/1994
Mumps
  *Not required if entered first grade before 7/1/1987 or entered college/university prior to 07/01/1994 or
  born before 1957
  *2nd dose not required if entered school or in college/university before 07/01/2008
Rubella
  *Not required if entered college/university after 30th birthday and before 02/01/1989 or attained 50th
  birthday
Titers are accepted, include Date/Result value of each

HPV
* Not required

POLIO – 4 doses
*Not required if 18 years of age or older

VARICELLA – 2 doses
*Not required if born before 04/01/2001
If History of Disease is provided, include Diagnosis Date or Age
Titers are accepted, include Date/Result value

MENINGOCOCCAL (A,C,Y,W) – 2 doses
EDUCATION REQUIRED for all students, Have you received education only about the vaccine? Please write
EDUCATION in Section B if you have received education.
North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide
information about meningococcal disease. Information is available from the CDC website, the Student Health
Center website, at the Student Health Center and at orientation.
*Not required if born before 01/01/2003

HEPATITIS A
*Not required

TB SKIN TEST (PPD or TST)
REQUIRED of International Students/Non-US Citizens from high risk countries
Must be administered within the past 12 months
if positive PPD, include date and result of chest x-ray. Attach treatment plan if applicable

PHYSICAL EXAMINATION
A physical examination is not required for admission to the University. If a student is taking a physical education course
and has a medical condition that may affect participation, the course instructor will request documentation of a physical or
will require the student to get a physical prior to participation.
### SECTION A REQUIRED IMMUNIZATIONS

All students must submit a combination of 3 DTP, Td or Tdap vaccines regardless of age. One MUST be within the past 10 years.

<table>
<thead>
<tr>
<th>Immunization Name</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP (Childhood Diphtheria, Tetanus, and Pertussis)</td>
<td></td>
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<tr>
<td>Td booster (Tetanus-diphtheria)</td>
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<td></td>
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<tr>
<td>Tdap booster (Tetanus-diphtheria and pertussis booster)</td>
<td></td>
<td></td>
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<tr>
<td>Polio (3 doses, only required if 17 years of age or younger)</td>
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<tr>
<td>MMR (Measles, Mumps, Rubella – 2 MMR vaccines required on or after first birthday OR 2 Measles, 2 Mumps and 1 Rubella single doses OR positive Measles, Mumps, Rubella titers)</td>
<td></td>
<td></td>
<td><strong>Disease Date</strong></td>
<td>****Titer Date &amp; Result</td>
</tr>
<tr>
<td>Measles (2 required on or after first birthday OR positive titer OR documented disease date)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps (2 required on or after first birthday OR positive titer)</td>
<td></td>
<td></td>
<td><strong>(Disease Date NOT Accepted)</strong></td>
<td>****Titer Date &amp; Result</td>
</tr>
<tr>
<td>Rubella (1 required on or after first birthday OR positive titer)</td>
<td></td>
<td></td>
<td><strong>(Disease Date NOT Accepted)</strong></td>
<td>****Titer Date &amp; Result</td>
</tr>
<tr>
<td>Hepatitis B Series (only required if born after July 1, 1994)</td>
<td></td>
<td></td>
<td></td>
<td><em><strong>Titer NOT Accepted for required Hep B Series</strong></em></td>
</tr>
</tbody>
</table>

### SECTION B RECOMMENDED IMMUNIZATIONS

Received the Meningococcal vaccine (Menactra, Menveo, Menomune, MPSV4, MCV4)? □ Yes □ No

If Yes, date(s) vaccine was received (at least one dose after the age of 16) (MM/DD/YYYY) #1: #2

<table>
<thead>
<tr>
<th>Immunization Name</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hepatitis A/B combination series</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pneumococcal</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td>Cervarix</td>
<td></td>
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<tr>
<td></td>
<td>Gardasil</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Varicella (chicken pox -2 doses, documentation of disease date or positive titer)</td>
<td></td>
<td></td>
<td><strong>Disease Date</strong></td>
<td>****Titer Date &amp; Result</td>
</tr>
<tr>
<td>Tuberculin Skin Test (TST)</td>
<td>Date Read</td>
<td>mm induration</td>
<td>mm</td>
<td>mm</td>
</tr>
<tr>
<td></td>
<td>Date of IGRA (QuantiFERON or T-SPOT) test</td>
<td></td>
<td>Result of IGRA test</td>
<td></td>
</tr>
</tbody>
</table>

**Signature of Health Care Provider**

**Printed Name of Health Care Provider**

**Office Address**

**City**

**State**

**Zip Code**

**Date**

**Area Code/Phone Number**
PHYSICAL EXAMINATION
(Print in black ink) To be completed and signed by a healthcare provider

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth (mo/day/year)</th>
<th>UNCW Student ID Number</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Area Code/Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Temperature/Pulse/Respiration</th>
<th>/</th>
<th>/</th>
<th>Blood Pressure</th>
<th>/</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

IF REQUIRED:
Vision Corrected
Right 20/________ Left 20/________
Uncorrected
Right 20/________ Left 20/________
Color Vision________

Hearing (Gross) Right________ Left________
15 ft Right________ Left________

IF REQUIRED:
Urinalysis
Sugar________ Albumin________
Micro________
Hgb or Hct (if indicated)________

STS (may be required by some departments):
Date________ Results________

Recommendations________

<table>
<thead>
<tr>
<th>Systems Review</th>
<th>Normal</th>
<th>Abnormal</th>
<th>DESCRIPTION (attach additional sheets if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Ears, Nose, Throat</td>
<td></td>
<td></td>
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<tr>
<td>Eyes</td>
<td></td>
<td></td>
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<tr>
<td>Respiratory</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Gastrointestinal</td>
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<tr>
<td>Genitourinary</td>
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<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Metabolic/Endocrine</td>
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<tr>
<td>Neuropsychiatric</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Mammary</td>
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</tbody>
</table>

A. Is there loss or seriously impaired function of any paired organs? YES________ NO________
Explain________

B. Is student under treatment for any medical or emotion conditions? YES________ NO________
Explain________

C. Recommendation for physical activity (physical education, intramurals, etc.).
   UNLIMITED_____ LIMITED_____
Explain________

D. Is student physically and emotionally healthy? YES________ NO________
Explain________

● Only for Students Admitted to a HEALTH SCIENCES PROGRAM ●

Based on my assessment of this student’s physical and emotional health on ______/_____/_______ he/she appears to be able to participate in the activities of a health profession in a clinical setting.

YES________ NO________

If no, explain________

Signature_________________________ Date________

Printed Name_________________________

Address_________________________

Phone#_________________________

Fax #_________________________
**THIS IS NOT YOUR HEALTH INSURANCE WAIVER**

<table>
<thead>
<tr>
<th>Name of Health Insurance Company</th>
<th>Area Code/Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address of Health Insurance Company</td>
<td>Policy Number / Subscriber ID Number / SSN</td>
</tr>
<tr>
<td>Name of Policy Holder</td>
<td>Relationship of Policy Holder to Student</td>
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</tbody>
</table>

**NAME OF PRIMARY EMERGENCY CONTACT**

**NAME OF SECONDARY EMERGENCY CONTACT**

**ADD/ADHD**
- Alcohol use
- Allergy injection therapy
- Anemia or Sickle cell anemia
- Anorexia/Bulimia
- Anxiety
- Arthritis
- Asthma
- Back injury
- Bladder infection
- Blood transfusion
- Bone, joint or other deformity
- Broken bone (specify)
- Chronic cough
- Concussion/Severe head injury
- Diabetes
- Disabling depression
- Dizziness or fainting spells
- Drug use
- Easily fatigued
- Excessive worry or anxiety
- Eye trouble besides glasses
- Frequent or severe headache
- Frequent vomiting
- Gall bladder trouble/gallstones
- Hay fever
- Head/neck radiation treatment
- Hearing loss
- Heart trouble
- Hernia
- High blood pressure
- High cholesterol
- Intestinal trouble
- Irregular periods
- Jaundice or hepatitis
- Kidney infection
- Kidney stone
- Knee problems
- Malaria
- Mumps
- Mononucleosis
- Neck injury
- Pain or pressure in chest
- Paralysis
- Pilonidal cyst
- Pneumonia
- Protein or blood in urine
- Rectal disease
- Recurrent back pain
- Regular Exercise
- Rheumatic fever
- Serious skin disease
- Severe menstrual cramps
- Sexually transmitted disease
- Shortness of breath
- Sinusitis
- Smoke/smokeless tobacco
- Throat trouble
- Tumor or cancer (specify)
- Ulcer (duodenal or stomach)
- Wear bicycle helmet
- Wear seat belt
- Other (specify)

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Use</th>
<th>Dosage</th>
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<tbody>
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<table>
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<tr>
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</table>
REPORT OF MEDICAL HISTORY-cont’d  
(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 (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following?

<table>
<thead>
<tr>
<th>ADVERSE REACTIONS TO</th>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penicillin</td>
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<tr>
<td>Sulfas</td>
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<tr>
<td>Other antibiotics (name)</td>
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<td></td>
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<tr>
<td>Aspirin</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Codeine</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other pain relievers</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other drugs, medicines, chemicals (specify)</td>
<td></td>
<td></td>
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<tr>
<td>Insect bites</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Food allergies (name)</td>
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</tbody>
</table>

If you answer YES, fully explain the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

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.

If you answer YES to any question, provide specific details for each response including when, where, and how.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any conditions or disabilities that limit your physical activities?</td>
<td></td>
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<tr>
<td>Have you ever been a patient in any type of hospital?</td>
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<tr>
<td>Has your academic career been interrupted due to physical or emotional problems?</td>
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<td></td>
</tr>
<tr>
<td>Is there loss or seriously impaired function of any paired organs?</td>
<td></td>
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<tr>
<td>Other than for routine check-ups, have you seen a physician or health care professional in the past six months?</td>
<td></td>
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<tr>
<td>Have you ever had any serious illness or injuries other than those already noted?</td>
<td></td>
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</tbody>
</table>

IMPORTANT INFORMATION...PLEASE READ CAREFULLY, SIGN and DATE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT IS UNDER AGE 18):

(A) I have personally supplied and reviewed the above information and attest that it is true and complete to the best of my knowledge. I understand that the information provided is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should become ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (if under 18 son/daughter's) medical record to a physician, hospital or other medical professional involved in providing care (if under 18 my son/daughter) emergency treatment or medical care.

(B) I hereby authorize any medical treatment for myself (if under 18 son/daughter) that may be advised or recommended by the medical staff of the Student Health Center.

(C) I am aware that the Student Health Center charges for some services and that I (if under 18 son/daughter) may be billed through the university student accounts cashier if the account is not paid at the time of visit. I (if under 18 son/daughter) accept personal responsibility for settling the account with the cashier and for payment of incurred charges. I am responsible for filing charges with my insurance company and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

Signature of Student

Date

Signature of Parent/Guardian, if student age 18

Date

Updated Spring 2018