St. Andrews
UNIVERSITY
*A Branch of Webber International University*

# HEALTH INFORMATION AND IMMUNIZATION FORM

**1700 Dogwood Mile**
**Laurinburg, NC 28352**
**Telephone: (910) 277-5145 • (800) 763-0198**
**Fax: (910) 277-5147**

## REQUIRED FORMS: Due Prior to Orientation Check-in

*Please keep a copy of these forms for future reference.*

☐ **Immunization Form:**

North Carolina Law GS 130z 152-157 requires all persons attending college to submit proper immunization records. If the immunization requirements are not met, registration for classes will be canceled.

☐ **Confidential Health Form:**

Provides a brief health history, to be completed by the student, listing any existing conditions and known allergies. This form must be signed by a parent if the student is not 18 years or older.

☐ **Copy of health Insurance Card and Prescription Card (Front and Back)**

☐ **Signed HIPPA Form**

☐ **Signed FERPA Form**

St. Andrews
UNIVERSITY
*A Branch of Webber International University*

# IMMUNIZATION DOCUMENTATION TO BE COMPLETED BY YOUR PHYSICIAN

NAME LAST FIRST MIDDLE DATE OF BIRTH

## SPECIAL INSTRUCTIONS FOR IMMUNIZATION DOCUMENTATION FORM

- Month, date and year for all immunizations must be documented.
- Please note you must show proof of tetanus immunization, both the initial series and a booster within the last 10 years.
- Only laboratory proof of immunization is acceptable for MMR. History of disease, even from a physician IS NOT ACCEPTABLE PROOF.
- Any medical exemption from the immunization requirements must be verified in a written statement from your physician.

**REQUIRED VACCINES:** *PLEASE INDICATE MONTH/DATE/YEAR*

**DPT, DT** or **TD** *(series of 3 injections required).* #1 ___. #2 ___. #3 ___. #4 ___. #5 ___.

**POLIO:** Oral series of 3 doses: #1 ___. #2 ___. #3 ___. #4 ___. #5 ___.

**TETANUS** booster *(within the past 10 years)* ***REQUIRED.*** _____.

**MMR#1** *(required)*: _____. **MMR#2** *(required)*: _____.

***OR*** **TITER DATE & RESULT** _____. *(Attach Lab Report)*

**TUBERCULIN SKIN TEST** ***(Required for International Students Only)***
***Not if Had BCG. Date of BCG*** _____.

**Date of TB Test:** _____.
**Results:** _____. **Negative:** _____. **Positive** *(please describe)* **mm induration.**

---

**Chest X-Ray** ***(Required if TB skin test is positive)*** **Date:** _____. **Results:** _____.
*(Please attach a copy of the Report)*

**HEPATITIS B SERIES:** #1 ___. #2 ___. #3 ___.

**TITER DATE:** _____. **Results:** _____.

**RECOMMENDED VACCINES**
VARICELLA SERIES: #1 ___. #2 ___.

MENINGOCOCCAL: _____. DISEASE DATE:_____. TITER DATE:_____. RESULT:_____.

**I certify the above named student has received the vaccines listed above on the dates specified.**

Physician Signature: _____

Please print or stamp physician or facility name, office address and phone number.

**RETURN ALL INFORMATION TO ARRIVE PRIOR TO CHECK-IN ON AUGUST 19TH TO:**

Revised 7/10/15

St. Andrews
UNIVERSITY
*A Branch of Webber International University*

## MENINGOCOCCAL DISEASE (MENINGITIS) AND VACCINE INFORMATION

Meningococcal disease is caused by bacteria called Neisseria meningitides. This bacterium is spread from person to person through respiratory secretions. Some individuals can be infected with the bacteria and yet exhibit no symptoms. They are unaware of the infection, yet can spread it to others. Others who are exposed to these bacteria will get significant infections, sometimes resulting in death. If the bacteria invade the bloodstream or other body tissues it can cause meningitis (inflammation of the membranes surrounding the brain and spinal cord), sepsis (infection of the blood stream), pneumonia (infection of the lings, or pharyngitis (sore throat).

Studies show that freshman entering college and residing in residential halls are at an increased risk of meningococcal disease relative to other persons of similar age. Due to this, it is recommended by the Center for Disease Control (CDC) that this vaccine be offered for other college students wanting to reduce their risk of this disease.

The vaccinations available that prevent this infection provide protection against serotypes A, C, Y and W – 135. They do not contain live bacteria. They are 85—100% effective in preventing disease from serotypes found in the vaccine, but they do not protect against serotype B.

More information about the disease and the vaccines can be found at the following websites:

- www.immunize.nc.gov/family/vaccines/meningococcal.htm
- www.cdc.gov/meningitis/about/faq.html

NC Session Law 2003-194, HB 825 requires that any private or public institution with a residential campus offering postsecondary degrees "shall provide vaccination information on meningococcal disease to each student".

**St. Andrews University**
**ATT: Office of Student Affairs**
**1700 Dogwood Mile, Laurinburg, NC 28352**
**Phone: (910) 277-5145 Fax: (910) 277-5147**

**Revised 7/10/15**

St. Andrews
UNIVERSITY
*A Branch of Webber International University*

# HIPAA CONSENT FORM

Please Print:
Student *(Patient)* Name: _____
LAST First Middle Initial

Social Security Number: _____ Date of Birth: _____

Student health Services reserves the right to release health information based upon a decision by your medical provider here for medical emergency situations and in general for continuity of care. We will use your health information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it.

Other than the above mentioned release, your personal healthcare information will NOT be released to others, including your parents(s), unless listed below.

Indicated by checking below, I give permission to provide information to the following:

☐ Parent/Guardian: _____
FULL NAME TELEPHONE

☐ SAU Athletic Training Staff and/or Program Director (FOR ATHLETES ONLY)

ATHLETIC Trainers/Program Directors will be notified based upon the Athletic HIPAA consent already on file of any condition/illness which may impact your trainer or participation as an athlete, with or without checking this box. Otherwise, if you do not check this box, we will only notify the training staff that you were, but no health information will be released.

☐ Other(s): _____
FULL NAME TELEPHONE

Student (Patient) Signature: _____

Witness Signature: _____
Any individual over the age of 18 who is present to witness the patient/student signature

Today's Date: _____

***HIPAA Consent to be renewed annually, or at any time when requested by the student.***

Revised 7/10/15

St. Andrews UNIVERSITY
*A Branch of Webber International University*

**Office of Student Affairs**
**St. Andrews University**
**1700 Dogwood Mile**
**Laurinburg, NC 28352**
**Phone: (910) 277-5145**
**Fax: (910) 277-5147**

# CONFIDENTIAL HEALTH FORM

Last Name | First Name | Middle Initial | Social Security Number | Telephone Number

Street Address | City | State | Zip | Date of Birth

Cell Phone Number | Age | Sex | Marital Status

Emergency Contact Person | Relationship | Telephone Number

ALLERGIES (food, drugs, other): _____

PERSONAL HISTORY (*PLEASE ANSWER ALL QUESTIONS*) *Comment on all yes answers in the space below

| HAVE YOU HAD: | Y | N | | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Frequent or Severe Respiratory Infections | | | Tuberculosis | | | Kidney or Bladder Problems | | | FEMALES ONLY | | |
| Ear, Nose, Throat Problems | | | Diabetes | | | Disease or injury of Bones or Joints | | | Irregular periods | | |
| Frequent or Severe Headaches | | | Anemia | | | "Trick" Knee or Shoulder | | | Severe Cramps | | |
| Rheumatic Fever or Heart Murmur | | | Hepatitis or Jaundice | | | Mononucleosis | | | Excessive Flow | | |
| Asthma, Hay Fever, Hives | | | Eye Problems | | | Disease or injury of Bones or Joints | | | | | |
| Stomach or Intestinal Problems | | | Epilepsy | | | | | | | | |

***If you checked yes to the questions concerning rheumatic fever or heart murmur, please provide an attached statement from your physician describing current conditions with emphasis on whether full participation in physical education activities is advisable.**

Do you have any disease that should be periodically evaluated? (Give Details)
Have you had any injury or operation or been hospitalized other than already noted? ___ YES ___ NO

Are you taking any medication on a regular basis?
(If yes, give details, i.e., Acne, Birth Control, Inhaler, etc.) ___ YES ___ NO

***COMMENTS** *(Use Additional sheet of paper if necessary)*

_____
_____
_____
_____

**STATEMENT BY THE STUDENT:** I have personally supplied the above information and attest that it is true and complete to the best of my knowledge; I hereby authorize any medical treatment advised or recommended by the licensed staff of the health and Wellness Center at St. Andrews University. I understand that student medical information is confidential and is used for providing medical care. I hereby give my permission for SAU Health and Wellness Center to release and obtain medical information to/from physicians, hospitals, mental health agencies or medical agencies that will benefit my total mental and physical health care at SAU. I also hereby give my permission for SAU Health and Wellness Center to release or obtain medical information to/from other colleges or universities.

Signature of Student: _____ Date: _____

I give consent for the SAU Administrative Staff to discuss my medical condition with my parents, guardian or significant other. Please Initial: Yes: _____ *or* NO: _____

**PARENTS OF STUDENTS UNDER AGE 18:** I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I hereby authorize any medical treatment for my son/daughter which may be advised or recommended by a licensed healthcare professional. I understand that student medical information is confidential and is used for providing medical care. I hereby give my permission for SAU Office of Student Affairs to release and obtain medical information to/from physicians, hospitals, mental health agencies or medical agencies that will benefit my child's total mental and physical health care at SAU. I also hereby give my permission for SAU Office of Student Affairs to release or obtain medical information to/from other colleges or universities.

Signature of Parent: _____ Date: _____