P.O. Box 128, Banner Elk, NC 28604
1-800-280-4562 admissions@lmc.edu
www.lmc.edu

STUDENT HEALTH AND IMMUNIZATION RECORD

The information on this form will be used as an aid in providing care, should you need it, while you are a student. It is confidential and will be released only to health care professionals and only when deemed necessary for your health. **YOU WILL NOT BE ALLOWED TO REGISTER FOR CLASSES UNTIL THIS FORM IS COMPLETED**. Please mail this completed form, along with your Housing Worksheet and Enrollment Deposit to: Admissions Office, Lees-McRae College, P.O. Box 128, Banner Elk, NC 28604.

Guidelines for Completing the Immunization Record

- Records must be documented in black ink and all corrections must be signed.
- All dates must include month, day and year of administration.
- Your immunization records may be obtained from your high school, physician, health department, military record or previously attended college. ***Be certain you check these records against the requirements listed below. It is your responsibility to assure you have had the required immunizations before submitting this form.***
- Records must include a physician's signature, health department stamp or high school record attachment.

Immunizations Required by North Carolina Statutes and Lees-McRae Policy

Students 17 Years of Age or Younger:

- 3 DPT (Diptheria, Tetanus and Pertussis) or Td (Tetanus and Diptheria) doses; one Td booster must have been within the past 10 years
- 3 Polio (oral) doses
- 2 Measles (Rubeola), 2 Mumps, 1 Rubella (2 MMR doses meet this requirement)
- Tuberculin Skin Test (PPD) and results within the 12 months preceding the beginning of classes (chest x-ray report required if test is positive)

Students Born in 1957 or Later and 18 Years of Age or Older:

- 3 DPT (Diptheria, Tetanus and Pertussis) or Td (Tetanus and Diptheria) doses; one Td booster must have been within the past 10 years.
- 2 Measles (Rubeola), 2 Mumps, 1 Rubella (2 MMR doses meet this requirement)
- Tuberculin Skin Test (PPD) and results within the 12 months preceding the beginning of classes (chest x-ray report required if test is positive)

Students Born Before 1957:

- 3 DPT (Diptheria, Tetanus and Pertussis) or Td (Tetanus and Diptheria) doses; one Td booster must have been within the past 10 years.
- 1 Rubella (MMR doses meet this requirement) - Not required if the student is 50 years of age or older
- Tuberculin Skin Test (PPD) and results within the 12 months preceding the beginning of classes (chest x-ray report required if test is positive)

** PLEASE NOTE:*

- History of Measles (Rubeola) is acceptable if physician verifies that the student had the disease prior to Jan. 1, 1994.
- Blood titer tests are acceptable for Measles (Rubeola,) Mumps, Rubella and Hepatitis B. Laboratory test results must be attached.
- Students who entered college for the first time after July 1, 1994, must have two doses of Measles (Rubeola) vaccine after their first birthday. Two MMR doses meets this requirement.

IMMUNIZATION RECORD

*To be completed and SIGNED by physician or clinic (Please use black ink)

Student's Last Name First Middle | Date of Birth | **Social Security Number

REQUIRED IMMUNIZATIONS					
		Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year
DTP or Td		(#1)	(#2)	(#3)	(#4)
Td Booster					
Polio					
MMR (After First Birthday)					
MR (After First Birthday)					
Measles (After First Birthday)				Disease Date	Titer Date & Result
Mumps				Disease Date NOT Accepted	Titer Date & Result
Rubella				Disease Date NOT Accepted	Titer Date & Result
Tuberculin (PPD Test) *Within 12 Months*	Date Read				
	MM Induration				
Chest X-Ray If Positive PPD	Date				
	Result				
Treatment, if applicable	Date				

OPTIONAL IMMUNIZATIONS			
	Month/Day/Year	Month/Day/Year	Month/Day/Year
Haemophilus Influenzae Type B			
Pneumococcal			
Meningococcal			
Hepatitis A Series			
Typhoid (Specify Type)			
Other			
Hepatitis B Series			

Signature of Physician, Physician Assistant or Nurse Practitioner | *Date*

Print Name of Physician, Physician Assistant or Nurse Practitioner | *Phone Number (with area code)*

Address *City* *State* *Zip*

**Signature or Clinic Stamp IS REQUIRED*

REPORT OF EMERGENCY INFORMATION

To Be Completed by Student (Please Use Black Ink)

Student's Last Name First Middle Date of Birth **Social Security Number

Permanent Mailing Address City State Zip Phone Number (with area code)

Gender ❑ Male ❑ Female Marital Status ❑ Single ❑ Married ❑ Other

Previously Enrolled Here? ❑ Yes ❑ No Class You Are Entering (Circle) FR SO JR SR Semester Entering (Circle) Fall Spring Summer1 Summer2

Student Athlete? ❑ Yes ❑ No Year 20__

Physician and Hospital Health Insurance Carrier (Name and Address of Company) Telephone

Name of Policy Holder Social Security Number Employer

Is This an HMO, PPO or Managed Care? ❑Yes ❑No

Policy or Certificate Number Group Number

Name of Person to Contact in Case of Emergency Relationship Daytime Telephone Nighttime Telephone

Address City State Zip

REPORT OF MEDICAL HISTORY

To Be Completed by Student, continued on back (Please Use Black Ink)

The following health history is confidential and does not affect your admission status. Except in an emergency situation by court order, this information will not be released without your written permission. *Please attach additional sheets for any items which require further explanation.*

ABOUT YOUR FAMILY Has any person, related to you by blood, had any of the following:

	Yes	No	Relationship
High Blood Pressure?			
Stroke?			
Heart Attack Before Age 55?			
Blood or Clotting Disorder?			

	Yes	No	Relationship
Cholesterol/blood fat disorder?			
Diabetes?			
Glaucoma?			
Overweight/Obesity?			

	Yes	No	Relationship
Cancer/Type?			
Alcohol/Drug Problems?			
Psychiatric Stress/?			
Committed Suicide?			

ABOUT YOU **Your height?** _____ **Your weight?** _____ Do you now have or have you ever had any of the following:

	Yes	No	Year?
High Blood Pressure?			
Rheumatic Fever?			
Heart Trouble?			
Chest Pain/Pressure?			
Shortness of Breath?			
Asthma?			
Pneumonia?			
Tuberculosis?			
Head/Neck Radiation Treatments?			
Tumor/Cancer? Specify.*			
Maliase?			
Diabetes?			
Serious Skin Disease?			
Mononucleosis?			
Hay Fever?			

	Yes	No	Year?
Allergy Shots?			
Concussion?			
Dizziness or Fainting Spells?			
Paralysis?			
Epileptic Seizures?			
Ulcer (Duodenal or stomach)			
Pilonidal Cyst?			
Gall Bladder Trouble?			
Gallstones?			
Jaundice or Hepatitis?			
Rectal Disease?			
Severe/Recurrent Abdominal Pain?			
Hernia?			
Anemia/Sickle Cell Anemia?			
Eye Trouble (NOT Glasses)?			

	Yes	No	Year?
Shoulder Dislocation?			
Knee Problems			
Recurrent Back Pain?			
Neck/Back Injury?			
Broken Bone? Specify.			
Kidney Infection?			
Kidney Stones?			
Bladder Infection?			
Protein/Blood in Urine?			
Hearing Loss?			
Sinusitis?			
Irregular Periods?			
Severe Menstrual Cramps?			
Blood Transfusion?			
Bone/Joint/Other Deformity?			
Arthritis?			

	Yes	No	Year?
Alcohol/Drug Use?			
Thyroid Trouble?			
Frequent/Severe Headaches?			
Severe Head Injury?			
Depression?			
Excessive Anxiety/ Worry?			
Intestinal Trouble?			
Frequent Vomiting?			
Easily Fatigued?			
Overweight/Obesity			
Sexually Transmitted Disease?			
Smoke 1+ Packs/Week			
Learning Disability?			
ADD/ADHD?			
Anorexia/Bulimia			
Other? Specify.*			

*Other/Specify _____

On a separate sheet, please describe in detail any condition or disability which would prevent participation in physical education.

Do you exercise 3 or more times a week? ❑ Yes ❑ No Do you use a seat belt on a regular basis? ❑ Yes ❑ No

Please list all drugs, medicines, birth control pills, vitamins and minerals (prescription and non-prescription) you use and indicate how often you use them.

Name/Dosage/Frequency _____ Name/Dosage/Frequency _____

Name/Dosage/Frequency _____ Name/Dosage/Frequency _____

REPORT OF MEDICAL HISTORY, CONTINUED

To Be Completed by Student, continued on back (Please Use Black Ink)

Check each item “Yes” or “No.” Each item checked “Yes” must be fully explained. Use a separate sheet if necessary.

	Yes	No	Explanation
Have you ever been a patient in any hospital? If “Yes,” please specify when, where and why?			
Has your academic career been interrupted because of physical or emotional problems? If “Yes,” please fully explain.			
Is there loss of or seriously impaired function of any paired organ? If “Yes,” please describe.			
Other than for a routine check-up, have you seen a physician or health care professional in the past 6 months. If “Yes,” please explain.			
Have you ever had any serious illness or injury other than those previously noted? If “Yes,” please specify when and where and give complete detail.			

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following. If “Yes,” please fully explain the type of reaction, your age when the reaction occurred and if the experience has occurred more than once.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other Antibiotics (Please List)			
Aspirin			
Codeine or Other Pain Relievers (Please List)			
Other Drugs, Medicines, Chemicals (Please List)			
Insect Bites			
Food Allergies (Please List)			

IMPORTANT INFORMATION

Signatures Required. (Please Use Black Ink)

STATEMENT BY STUDENT OR PARENT/GUARDIAN (IF STUDENT IS UNDER THE AGE OF 18)

I have personally supplied and/or reviewed the information on this form and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my consent unless by court order. However if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission for the Student Health Service to release information from my medical record to a physician, hospital or other medical agency involved in providing me with emergency treatment and/or medical care.

Signature _____ Date _____

STATEMENT BY STUDENT OR PARENT/GUARDIAN (IF STUDENT IS UNDER THE AGE OF 18)

I authorize any medical treatment for my son/daughter which may be advised or recommended by the medical staff of the Student Health Services at Lees-McRae College.

Signature _____ Date _____