METHODIST UNIVERSITY

Methodist University Health Services
5400 Ramsey Street, Fayetteville, NC 28311-1498
910.630.7164 | muhc@methodist.edu

For digital transmission, visit methodist.edu/health-services.

Last Name: _____ First Name: _____

MU Student ID #: _____ Student Phone #: _____

Year Attending: _____ Fall: _____ Spring: _____

Year Attended if Returning Student: _____

Student-Athlete? YES NO Sport: _____

International Student? YES NO Physician Assistant Student? YES NO

Nursing Student? YES NO Occupational Therapy Student? YES NO

Physical Therapy Student? YES NO

Methodist University Health Center
IMMUNIZATION REQUIREMENTS

Fall deadline: July 1st
Spring deadline: December 1st

All students are required to submit immunization records under North Carolina Law Unless:

- Off campus courses
- Evening courses (Start at 5:00 PM or later)
- No more than four traditional day credit hours
- Weekend courses

IMMUNIZATIONS that are REQUIRED pursuant to NC state law MUST BE LISTED ON THE MU FORM AND COMPLETED BY CLINIC.

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. They will be screened carefully by this institution and if deficiencies are found the student will be notified and will be given a reasonable period to comply.

Immunizations must be in compliance ***no later than 30 days upon registering for classes.*** Students who fail to comply with these requirements will not be permitted to remain in attendance at Methodist University. This is fully enforced.

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT

- Records must be documented in BLACK INK and all corrections must be signed.
- Submit immunizations **in English** by mm/dd/yy Example: 12/31/12

SECTION A: Undergrad Students, Physician Assistant, Physical Therapy, Occupational Therapy and Nursing. Required

DTP (3Does): 3 Doses of the Tetanus/diphtheria toxoid of which one must be a tetanus/diphtheria/pertussis (Tdap) a Td booster is needed every 10 years.

Polio (3 Doses): An individual attending school who has attained his or her 18th birthday is not required to receive the polio vaccine.

Measles (2 Doses): An individual born prior to 1957 is not required to submit proof of immunizations. An individual may submit a titer lab report documenting that they have a protective antibody against the Measles.
Mumps (2 Doses): An individual born prior to 1957 is not required to submit proof of immunizations. An individual may submit a titer lab report documenting that they have a protective antibody against the Mumps.
Rubella (1 Dose): An individual born prior to 1957 is not required to submit proof of immunizations. An individual may submit a titer lab report documenting that they have a protective antibody against Rubella.

Hepatitis (3 Doses): An individual is not required to submit proof of vaccine if born before July 1, 1994. Any student entering in the medical field must show proof of these vaccines.
Varicella (1 Dose): An individual born after April 1, 2001 is required to submit proof of one dose of varicella vaccine

NOTE: Blood titer tests are acceptable for Measles, Mumps, Rubella and Varicella. A laboratory test results must be attached.

SECTION B: Physician Assistant, Physical Therapy, Occupational Therapy and Athletic Training. Required

Varicella (2 Doses): An individual must show proof of these vaccines or a titer lab report documenting that they have a protective antibody against the Chicken Pox.
Tuberculin: An individual must show a TB skin test twelve months before entering into the programs.
Physical: An individual is required to submit a physical within four months before entering into the program.

SECTION C: Nursing. Required

Tuberculin: Any individual must show a two-step TB skin test within four months before entering the program.
Physical: An individual is required to submit a physical within four months preceding entering the program.
Influenza: must be within the current year.
Varicella (2 Doses): An individual entering the medical field must show proof of these vaccines or a titer lab report documenting that they have a protective antibody against the Chicken Pox.

SECTION D: Optional but recommended

Meningococcal (2 Doses): The CDC recommends that college students living in residence halls be educated about meningitis and the benefits of vaccination. To learn more, visit the CDC website at https://www.cdc.gov/vaccines/vpd/mening/index.html
COVID-19:Pfizer/Moderna-(2 doses), Johnson and Johnson (1 dose), 1 booster of Pfizer or Moderna.
To learn more visit CDC website at cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html

THIS PAGE MUST BE COMPLETED BY A CLINICIAN

IMMUNIZATION RECORD (Please type or print in black ink)

Last Name, First Name, Middle Name	Date of Birth mo/day/year	

SECTION A: Undergrad Students, Physician Assistant, Physical Therapy Occupational Therapy and Nursing. Required

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
• DTP or Td				
• TDAP Booster				
• Polio				
• Hepatitis B Series (if born after July 1,1994)				
• Measles (MMR)			Disease Date	Titer Date & Result
• Mumps (MMR)				Titer Date & Result
• Rubella (MMR)				Titer Date & Result
• Varicella (chicken pox) (if born after April 1, 2001) one doses or positive blood titer				Titer Date & Result

SECTION B: Physician Assistant, Physical Therapy and Occupational Therapy. The following immunization are required

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
• Hepatitis B series				
• Varicella (chicken pox) series of two doses or immunity by positive blood titer.				Titer Date & Result
• TUBERCULIN (PPD) Test **Date Results**				
Chest x-ray, if positive PPD **Date Results**				
Treatment, if applicable **Date Results**				

SECTION C: Nursing. The following immunizations are required

• Hepatitis B series				
• Varicella (chicken pox) series of two doses or Immunity by positive blood titer.				Titer Date & Result
• Two- Step TUBERCULIN (PPD) Test	First Date	First Results	Second Date	Second Results
Chest x-ray, if positive PPD **Date Results**				
Treatment, if applicable **Date Results**				
• **Influenza must be within the current year**				

SECTION D: Optional

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
• Meningococcal (serogroup A,C,Y &W-135)	Menactra	Menactra	Menveo	Menvo
• Meningococcal B	Bexsero	Bexsero	Trumenba	Trumenba
• COVID-19 Pfizer (2 dose) booster				
COVID-19 Moderna (2 dose) booster				
COVID-19 Johnson & Johnson (1 dose)				

Clinician Signature or Clinic Stamp_____ Telephone _____

Office Address_____ Date _____

Report of Medical History (Please type or print in black ink)

LAST NAME (print) FIRST NAME MIDDLE NAME

PERMANENT ADDRESS CITY STATE ZIP AREA CODE/PHONE

DATE OF BIRTH (mo/day/yr)_____ GENDER M F MARITIAL STATUS S M OTHER

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) TELEPHONE

NAME OF POLICY HOLDER EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS AREA CODE/PHONE

The following health history is confidential, does not affect your admission status and (except in an emergency situation or by court order will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY AND PERSONAL HEALTH HISTORY (Please type or print in black ink)

Has any person related by blood, had any of the following?

	Yes	No	Relationship
High blood pressure			
Stroke			
Cancer :(type)			
HeartAttack before age 55			

	Yes	No	Relationship
Cholesterol or blood fatdisorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Blood or clotting disorder			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT_____WEIGHT_____

Have you ever had or have you now: (please check at the right of each item and if yes indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic Fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Tuberculosis			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Serious skin disease			
Alcohol/drug use			
Sexually transmitted disease			

	Yes	No	Year
Mononucleosis			
Hay Fever			
Head or neck radiation treatment			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Sever head injury			
Paralysis			
Epilepsy/Seizures			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			

	Yes	No	Year
Self-induced vomiting			
Frequent vomiting			
Gall bladder trouble or gallstones			
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle cell anemia			
Eye trouble besides needing glasses			
Bone, joint or other deformity			
Shoulder dislocation			
Knee problems			
Recurrent back pain			
Neck injury			

	Yes	No	Year
Back injury			
Broken bones			
Kidney infection			
Bladder infection			
Kidney stone			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Blood transfusion			
Smoke 1+ pack cigarettes/week			
Diabetes			
Anorexia/Bulimia			
Allergy injection therapy			

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

Name_____Use_____Dosage_____ Name_____Use_____Dosage_____

Name_____Use_____Dosage_____ Name_____Use_____Dosage_____

PERSONAL HEALTH HISTORY (Please type or print in Black ink)

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? If yes please explain fully the type of reaction, your age when the reaction first occurred, and if the experience has occurred more than once.

	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Have you ever been a patient in any type of hospital? (Specify when, where and why.)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there any loss or seriously impaired function of any paired organs? (Please describe)			
Other then for a routine check-up, have you seen a physician or health-care professional in the last six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details.)			

IMPORTANT INFORMATION ... PLEASE READ AND COMPLETE

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 understand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court order. However, if I should become ill or injured and unable to sign the appropriate forms, I hereby give my permission for Student Health Services 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 of Student Date

PARENT/GUARDIAN OF STUDENT UNDER 18 years: I hereby authorize any medical treatment for my son/daughter that may be advised or recommended by the physicians of the Student Health services.

_____ _____

Signature of Parent/Guardian if under 18 years Date

PHYSICAL EXAMINATION (Please type or print in black ink.)

- **A PHYSICAL EXAMINATION IS REQUIRED FOR ALL STUDENT ATHLETES AND HEALTH CARE PROFESSIONS**

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	MU ID Number

Permanent address	City	State	Zip Code	Area Code/Phone Number

Height_____ Weight_____ TPR_____/_____/_____ BP_____/_____

Vision: Corrected Right 20/_____ Left 20/_____ Uncorrected Right 20/_____ Left 20/_____ Color Vision_____

Hearing: (gross) Right_____ Left_____ 15 ft. Right_____ Left _____

Urinalysis: Sugar:_____ Albumin_____ Micro_____ Hgb or Hct (if indicated)_____

Are there abnormalities? If so, describe fully	Yes	No	Description (attach additional sheets if necessary)
1, Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes_____ No _____
Explain _____

B. Is student under treatment for any medical or emotional condition? 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 STUDENT ATHLETES

Based on my assessment of this student's physical and emotional health on_____(he / she) appears able to participate in intercollegiate sports Yes_____ No_____ If No, please explain _____

ONLY FOR STUDENTS ADMITTED TO A HEALTH CARE PROFESSION

Based on my assessment of this student's physical and emotional health on_____(he / she) appears able to participate in the activities of a health profession in a clinical setting. Yes_____ No_____ If No, please explain _____

Signature of Clinician Date

Print Name of Clinician Date

Office Address Area Code/Phone Number

Required for Student-Athletes Only:

For participation in intercollegiate athletics, all student-athletes must verify their sickle cell trait status prior to participation in a sport without regard to risk factors. Student-athletes will be unable to participate without this verification. If the perspective student-athlete has previously undergone testing, most were tested at birth, contact their pediatrician (at birth) for a copy of test results. Submit these results along with the physical exam form. A copy of documentation from previous test will be accepted as a substitute for a signature below. If not previously tested for the trait, please conduct testing at this time and record results in the selection below.

Student-Athlete's Name: _____

Sickle Cell Trait Positive: _____ Sickle Cell Trait Negative: _____ Date of Test: _____

Physician/Medical Provider: _____ Date: _____

Address: _____ Phone: _____

If you have a question or concern or would like more information on sickle cell trait testing or the NCAA requirement, please contact the Director of Athletic Training Services/Head Athletic Trainer at telephone number 910-630-7596.