QUEENS UNIVERSITY of CHARLOTTE

Student Medical Form

Instructions for Completing Medical Form

DEADLINE FOR COMPLETED MEDICAL FORMS AUGUST 1

$100 Late Fee for Incomplete Records or Records Received after August 1

Read Carefully

1. **MANDATORY requirements for all new students (Freshman, Transfers and International)**

   - [ ] Tuberculin Skin Test (PPD) within the last year.
   - [ ] Immunizations * required pursuant to North Carolina State Law.
     - 3 DTP (Diphtheria, Tetanus, and Pertussis) Tdap Booster must have within the last 10 years.
     - 2 MMR (Measles, Mumps, Rubella).
     - Hepatitis B Series required if born after 7/1994.
   - [ ] Physical Exam within last 12 months.
   - [ ] Medical History (completed by student).

2. **Ask your physician to review the information you provided and to complete the remainder of the form. Make sure that he/she:**

   - Reviews the immunization history and updates all necessary immunizations.
   - Signs the bottom of the page certifying that your medical history, immunizations, PPD and physical examination are complete.
   - All dates must include month, day and year.

3. **Students who plan to play intercollegiate sports** must send this completed form to the Health and Wellness Center in addition to any Athletic requirements. Our requirements are different and BOTH are necessary.

4. **Check your medical form for completion.** Sign and mail to the address listed below. Questions regarding this form should be directed to Student Health and Wellness Services, (704) 337-2220

Please enclose a front and back copy of your insurance card when you submit your medical form

***All records must be legible and in English.**

Upon completion of Student Medical Form, please return to:
Queens University of Charlotte HWC
1900 Selwyn Ave., Charlotte, NC 28274
Fax: (704) 337-2333
or email: medicalrecords@queens.edu

QUEENS UNIVERSITY of CHARLOTTE

Student Medical Form (p. 2)

Report of Medical History

IMPORTANT: This form must be completed, returned to the HWC and found complete by Student Health & Wellness Services. Information supplied will be used as an aid in providing necessary care while you are a student. The information is strictly for the use of Student Health and Wellness Services and will not be released to anyone without your knowledge and consent.

Last Name (print) First Name Middle Name Social Security Number

Permanent Address City State ZIP

Student's Cell Phone Date of Birth (mo/day/yr)

Marital Status (circle one): S M Other

Class You Are Entering : FR SO JR SR

Previously Enrolled Here (circle one): Yes No Other

Semester Entering: Fall Spring Year 20_____

Please enclose a front and back copy of your insurance card when you submit your medical form.

Name of Person to Contact in Case of an Emergency Relationship

Address Area Code/Telephone (Home) Area Code/Telephone (Work)

Area Code/Telephone (Cell) Emergency Contact Email

Family & Personal Health History

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.

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

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High Blood pressure				High Cholesterol				Blood disorder			
Stroke				Blood fat disorder				Alcohol/drug problems			
Cancer (type:)				Diabetes				Psychiatric illness			
Heart attack before age 55				Glaucoma				Suicide			

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

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
High Blood pressure				Hay Fever				Hernia				Severe menstrual cramps			
Rheumatic Fever				Head or neck radiation				Anemia or Sickle Cell				Irregular periods			
Heart Trouble				Arthritis				Eye trouble besides need for glasses				Blood transfusion			
Pain/pressure in chest				Concussion				Bone or joint deformity				Smoke 1+ pack cigarettes/week			
Shortness of breath				Frequent/sever e headache				Shoulder dislocation				Allergy injection therapy			
Asthma				Dizziness or fainting spells				Knee problems				Alcohol/drug abuse			
Pneumonia				Severe head injury				Recurrent back pain				Depression			
Chronic cough				Paralysis				Neck Injury				Self---injury			
Tuberculosis				Epilepsy/Seizures				Back injury				Suicide attempt			
Tumor or Cancer(specify)				Ulcer (stomach)				Broken bones				LD/ADD/ADHD			
Malaria				Intestinal trouble				Kidney infection				Bipolar disorder			
Thyroid trouble				Diabetes				Bladder infection				Anxiety/panic			
Serious skin disease				Frequent Vomiting				Kidney stone				Sleep problems			
Easy fatigability				Jaundice or hepatitis				Chickenpox(Disease)				Eating disorder			
Sexually transmitted illness (STI)				Rectal Disease				Hearing loss							
Mononucleosis				Severe/recurrent abdominal pain				Sinusitis							

QUEENS UNIVERSITY of CHARLOTTE

Student Name ____________________

Student Medical Form (p.3)

(Family & Personal Health History continued)

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

Name________________Use:_______________Dosage:_________Name_________________Use:_______________Dosage:_________

Name________________Use:_______________Dosage:_________Name_________________Use:_______________Dosage:_________

Name________________Use:_______________Dosage:_________Name_________________Use:_______________Dosage:_________

Please describe any conditions or disabilities that would exclude participation in physical education:

____

Do you exercise three or more times per week? Yes or No

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 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 because of physical or emotional problems?			
Have you ever been in a residential program for substance or mental health treatment?			
Other than a routine check-up, have you seen a physician or health-care professional in the past six months?			
Have you ever had any serious illness or injuries other than those already noted? (Specify when, where and give details.)			

☐ I would like for a counselor from the Health & Wellness Center to contact me about mental health resources on campus.
If you checked the box, please list your preferred contact method: Phone_________________Email___________________________

STATEMENT BY STUDENT (*OR PARENT/GUARDIAN IF STUDENT UNDER AGE 18*)

(A) 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 otherwise permitted by law. If I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission to Student Health Services to release information from my *(son/daughter)'s* medical records to a physician, hospital, or other medical personnel involved in providing me *(him/her)* with emergency treatment and/or medical care. **(B)** I hereby authorize any medical treatment for myself *(my son/daughter)* that might be advised or recommended by the providers of the Student Health & Wellness Center. **(C)** I am aware that the Health & Wellness Center charges for some services and I will be billed through the Business Office. I accept personal responsibility for settling the account with the cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

Student Signature ____________________ **Parent/Guardian Signature** ***(if student under 18)*** ____________________ ***Date*** ____________________

QUEENS UNIVERSITY of CHARLOTTE

Student Medical Form (p.4)

Report of Health Evaluation

Student Medical Form *Checklist*

- Ensure all immunizations are listed (according to NC State Law) Make sure the physician completes and signs physician form
- Enclose a copy of the front and back of insurance card (does NOT constitute insurance waiver).
- Make sure your Tuberculin (PPD) test is current (within 12 months)
- Make a copy for your records

Last Name **First Name** **MI** **Date of Birth (mm/dd/yyyy)**

TO EXAMINING PHYSICIAN: Please review the student's medical history, immunization history, proof of PPD, and then complete the examination and general comments portion of this form.

Vaccine	Series Date	Series Date	Series Date	Booster Date	Booster Date
DTP (Date of series Required)	**#1**	**#2**	**#3**	**#4**	
Tdap **(Booster within 10 years)**		**Required**			
Polio, oral					
Hepatitis B **(Required)**					
Hepatitis A **(recommended)**					
MMR (Measles, Mumps, Rubella)	**#1**	**Booster required: #2**			
Meningococcal **(recommended)**					
Gardasil – HPV Vaccine**(recommended)**	**#1**	**#2**	**#3**		
Tuberculin (PPD) test Date given					
(within 12 months) Date read		**Results**	**mm induration**		
Chest x-- - ray, if positive PPD Date					
Result					
Treatment, if applicable Date					
Notes:					

The North Carolina Immunization Law *requires that students entering college present to the school authorities immunization certif i cation.*

Please note that if this requirement is not met, dismissal from school 30 days after registration is mandatory under the law.

Please Do Your Part *to make sure you have the minimum immunization required before sending in your form.*

Height Weight BP Pulse Temp.

Vision R 20/ L 20/ Corrected Hearing (Gross) R L

Are there abnormalities of the following systems?

System	Yes	No	System	Yes	No
1. Head, Ears, Nose, Throat			9. Musculoskeletal		
2. Eyes			10. Metabolic/Endocrine		
3. Respiratory			11. Neuropsychiatric		
4. Lymphatic			12. Skin		
5. Cardiovascular			*Describe fully.*		
6. Gastrointestinal					
7. Hernia					
8. Genitourinary					

General Comments (diagnosis, recommendation, etc.)

Physical Activity?

Limited or Unlimited Explain: ____

Is this student now under treatment for any medical or emotional conditions? Yes or No

Name of Provider (Print) Date Signature of Provider

Office Address (or Office Stamp) Area code/Office Telephone