Dear Perspective Student:

On behalf of the Health Services team we would like to welcome you to Livingstone College. This letter is an aid to help you get your health records completed and turned in 30 days prior to enrollment. In the health packet there will be:

- **Demographics Page** contains the medical history for the student. All blanks should be filled in- including insurance status, along with a copy of the insurance card and drug allergy information. The student should fill in this portion; or a parent or guardian may do so if the student is under the age of 18.

- **Physical Examination Page** is the physical portion and is filled in by the physician. Your physical must have been completed within a 12 month period from enrollment. The physician may or may not perform a urinalysis or perform labs. It is dependent upon the health of the student.

- **Laboratory/Immunization Page**. Immunization records must be signed by a Physician or Nurse Practitioner including the address and phone number of the provider. For North Carolina students a high school transcript is not an acceptable record of immunization. Immunization records must be received on or before the student first registers for classes.

- **Meningococcal Vaccine Declination Page.** Complete the form, sign and check “A” if you do not wish to receive the vaccine.

- **Tuberculosis (TB) Screening Page.** TB screening tool must be completed by all students. An answer of yes to any question requires a TB skin test with results.

**North Carolina State Law Immunization Requirements**

Immunization requirements apply to all students except those residing off campus and registering for any combination of: off campus courses, evening courses (those which start after 5pm), weekend courses and taking no more than 4 credit hours in on campus courses. If at any time any of the above changes, the student needs to submit a certificate of immunization on or before the first date of registration.

- **Tetanus- DTP, DT, TD/TDap**- series of (3) doses. Under administrative rule 10A NCAC 41A.0401 those students entering a college or university for the first time after July 1, 2008 are required to have a booster dose of Tdap (tetanus/diphtheria/acellular pertussis ) within the past 10 years.

- **Polio**-a series of (3) doses. Not required if over the age of 18.

- **MMR** (measles, mumps and rubella) 2 doses.

- **Hepatitis B**-a series of 3 doses required for those students born 1994 and after. HepB Titors are not recognized by North Carolina Immunization Registry (NCIR)

- **Varicella Vaccine** – First dose required.

**Recommended Immunizations**

- Meningococcal-if student doesn’t want to take vaccine, please sign the vaccine declination sheet.
- HPV
- Hepatitis A
- Varicella –Second dose
- Flu

If a student must begin a series of injections in order to be in compliance; such will be completed before the student can legally remain in college. Those students that do not turn in immunization
records prior to enrollment will be given 30 calendar days from the first day of registration in order to become compliant. If the immunization requires a series of doses and the period necessary to give the vaccine at standard intervals extends beyond the date of the first registration, the student shall be allowed to attend the college. **If after that time, they will be withdrawn from classes, will not be able to participate in sports and cannot live in the Residence Halls.**

The student health forms are located on the website of Livingstone College. Visit http://www.livingstone.edu and click on “Students”, scroll down to Student Web Portal, click Health Service, scroll to Student Health Information and click to download. You will see all the student health forms to complete. You may choose to bring your forms with you during registration or return your forms in advance any of the following methods:

**Mail:** Student Health Center, 701 W. Monroe St., Salisbury NC. 28144  
**Fax:** 704-216-6770  
**Email:** Sheila Wasson RN, Director Student Health Center swasson@Livingstone.edu  
Charlonda Caple, Administrative Assistant ccaple@livingstone.edu
### PHYSICAL EXAMINATION

(To be completed by physician, PA, FNP, or certified clinician)

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Any loss or serious impairment to any organ? __________________________

Is Student being treated for medical or emotional condition? __________________________

Is Student capable of unlimited athletic participation? __________________________

Remarks pertinent to history or physical findings __________________________

Signature of Physician __________________________ Date __________
Name: _______________________________ Date of Birth: _______________________________

LABORATORY

HEMOGLOBIN

URINALYSIS: GLUCOSE __________________________ ALBUMIN __________________________

REQUIRED IMMUNIZATIONS

DTP, DTap, TD (proof of 3 doses required) 1. __________ 2. __________ 3. __________ 4. __________ 5. __________

TD/Tdap (Tdap required for all freshmen, TD within the last 10 years) 1. __________________________

POLIO (a series of 3. If over the age of 18 not required) 1. __________ 2. __________ 3. __________ 4. __________ 5. __________

MMR-Measles, Mumps and Rubella (a series of 2. The first dose must have been given on or after the first birthday. Not required after the age of 50). Serological titers acceptable to verify immunity. 1. __________________________ 2. __________________________

HEPATITIS B (a series of 3. If born after 1994) 1. __________ 2. __________ 3. __________

NEGATIVE TB SCREENING OR TB SKIN TEST (required within the past year.) Tuberculin lot # __________ Exp. date __________ Given by: __________

Date given: __________ Date read: __________ Result: __________________________

VARICELLA 1. __________________________

****If there is a history of a positive TB test in the past, please provide chest x-ray results. ****

RECOMMENDED IMMUNIZATIONS

MENINGOCOCCAL (A dose of 1. If the first dose was given at age 13 through 15 years, a one-time booster dose should be administered at 16-18 years)

1. __________________________ 2. __________________________

Which dose administered? (Please check) Menactra __________________________ Menveo __________________________

HPV-GARADSIL (a series of 3 for females and males up to the age of 26) 1. __________ 2. __________ 3. __________

VARICELLA 2. __________________________

HEPATITIS A (series of 2) 1. __________________________ 2. __________________________

PHYSICIAN SIGNATURE OR CLINIC STAMP __________________________________________________________________ DATE __________________________________________________________________

Address __________________________________________ Phone Number: __________________________
MENINGOCOCCAL VACCINE WAIVER FORM

MUST BE COMPLETED AND SUBMITTED IF STUDENT DOES NOT RECEIVE VACCINE

MENINGOCOCCAL DISEASE (Meningitis) Meningococcal disease is a bacterial infection caused by the *Neisseria meningitidis*. The bacteria colonize in the inner lining of nasal passages. From there they can make their way into the bloodstream. If the bacteria multiply very quickly in the bloodstream this can lead to a severe blood infection called meningococcemia. The bacteria can also get carried to the brain and spine where they can attack the membranes covering the brain and spinal cord. These membranes are called meninges. This causes swelling. When this happens the disease is referred to as bacterial meningococcal meningitis. The disease is rare; however its initial flu-like symptoms make diagnosis difficult. Meningococcal bacteria are spread from person to person through close contact. The disease progresses rapidly and leads to death within 24-48 hours from the first sign of symptoms. Infants and adolescents are particularly vulnerable. Adolescents are at higher risk of contracting meningococcal disease because of several social and environmental factors such as: crowding, kissing, pubs/clubs, and residence halls. In the United States, the annual estimated incidence of meningococcal disease in adolescents and young adults (14-24 years old) was observed to be 0.75 cases per 100,000 individuals.

Vaccination is considered to be the most effective method of preventing meningococcal disease. A number of different vaccines are currently available for bacteria types A, C, W-135 and Y. Presently there is no vaccine available to protect against type B bacteria. In January 2011, the Advisory Committee on Immunization Practices (ACIP) recommended routine vaccination with a single dose vaccine for adolescents, optimally at age 11 or 12 years followed by revaccination at age 16 years, 5 years after the first dose received because there is a potential decline of immunity after 5 years.

Additional information can be obtained on the Centers for Disease Control and Prevention (CDC) website at: http://www.cdc.gov/health/diseases.htm.

Student Name (please print) Last_________________________ First_________________________ MI__________

Student ID number ___________________________ Date of Birth ___________________________

If student is under the age of 18, parent or legal representative please sign:

Name:_________________________________________ relation to student __________________________

I have read the information on meningococcal disease and:

(Mark either A or B)

A. I DO NOT wish to receive the meningococcal vaccine.
B. I have already received the vaccine on this date: __________________________.

Student Signature (over the age of 18)________________________________________
Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease?  
- Yes  
- No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)  
- Yes  
- No

Afghanistan  
Algeria  
Angola  
Anguilla  
Argentina  
Armenia  
Azerbaijan  
Bangladesh  
Belarus  
Belize  
Benin  
Bhutan  
Bolivia (Plurinational State of)  
Bosnia and Herzegovina  
Botswana  
Brazil  
Brunei Darussalam  
Bulgaria  
Burkina Faso  
Burundi  
Cabo Verde  
Cambodia  
Cameroon  
Central African Republic  
Chad  
China  
China, Hong Kong SAR  
China, Macao SAR  
Colombia  
Comoros  
Congo  
Côte d'Ivoire  
Democratic People's Republic of Korea  
Democratic Republic of the Congo  
Dominican Republic  
Eritrea  
Ecuador  
El Salvador  
Equatorial Guinea  
Ethiopia  
Gabon  
Gambia  
Georgia  
Ghana  
Greenland  
Guam  
Guatemala  
Guinea  
Guinea-Bissau  
Guyana  
Haiti  
Honduras  
India  
Indonesia  
Iraq  
Kazakhstan  
Kenya  
Kiribati  
Kuwait  
Kyrgyzstan  
Lao People's Democratic Republic  
Latvia  
Lesotho  
Liberia  
Libya  
Lithuania  
Madagascar  
Malawi  
Malaysia  
Maldives  
Mali  
Marshall Islands  
Mauritania  
Mauritius  
Mexico  
Micronesia (Federated States of)  
Mongolia  
Montenegro  
Morocco  
Mozambique  
Myanmar  
Namibia  
Nauru  
Nepal  
New Caledonia  
Nicaragua  
Niger  
Nigeria  
Northern Mariana Islands  
Pakistan  
Palau  
Panama  
Papua New Guinea  
Peru  
Philippines  
Portugal  
Qatar  
Republic of Korea  
Republic of Moldova  
Romania  
Russian Federation  
Rwanda  
Sao Tome and Principe  
Senegal  
Serbia  
Sierra Leone  
Singapore  
Solomon Islands  
Somalia  
South Africa  
South Sudan  
Sri Lanka  
Suriname  
Swaziland  
Syrian Arab Republic  
Tajikistan  
Tanzania (United Republic of)  
Thailand  
Timor-Leste  
Togo  
Tunisia  
Turkey  
Tuvalu  
Uganda  
Ukraine  
Uruguay  
Uzbekistan  
Vanuatu  
Venezuela (Bolivarian Republic of)  
Viet Nam  
Yemen  
Zambia  
Zimbabwe


Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above)  
- Yes  
- No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?  
- Yes  
- No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?  
- Yes  
- No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?  
- Yes  
- No

If the answer is YES to any of the above questions, Livingstone College requires that you receive TB testing and results as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing or further action is required.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.
Demographics (TO BE COMPLETED BY THE STUDENT)

NAME: Last__________________________ First__________________________ Middle initial______ Date of Birth______________

Home Address:________________________________________________________ City_____________________________________

State__________________________ Zip__________________________ Cell/Home Phone: ( )__________________________

Emergency Contact: (name, phone number)______________________________________________________________

Proposed Registration (please check) Fall____ Spring____ Summer_____ Year____ Previously enrolled? Y____ N____ Year____

Are you covered with Medical Insurance? Y____________ N____________ If yes, please provide a copy of the front and back of your insurance card.

Are you allergic to any medications? Y_______ N_______ If so, please list the name and type of reaction______________

Is there any disease or treatment that should be evaluated periodically? If so, please explain______________________________

Personal Health History

Do you have a history of any of the following? Y=yes N=no

Anorexia_________ Gastrointestinal Disorder_________

Arthritis_________ Heart Disease_______________

Asthma/Hay Fever/Hives_________ Hepatitis_________

Diabetes_________ High Blood Pressure_________

Ear/Nose or Throat trouble_________ Kidney Disease_________

Eczema_________ Migraine Headache_______________

Emotional Conditions_______________ Mononucleosis_______________

Epilepsy (Seizures)_______________ Sickle Cell Trait_______________

Statement by student, Parent or Legal Guardian (if student under the age of 18): I attest that the submitted health information above is true and complete to the best of my knowledge. I hereby give permission to any physician, Hospital or other medical agency as appropriate to advise and render medical treatment as necessary.

Signature of Student_________________________________________________________ or Legal Guardian________________________________________ Date:_________