PRE-ENTRANCE MEDICAL RECORD
Complete and return to:

Admissions Office Room 307,
Halifax Community College
P.O. Drawer 809, Weldon, NC 27890
(252) 536-7220
International Student
GUIDELINES FOR COMPLETING IMMUNIZATION RECORD FOR INTERNATIONAL STUDENTS

IMPORTANT
- Records must be documented in black INK and all corrections must be signed.
- All dates must include month, day and year of administration.
- Immunizations required for the appropriate age group as outlined below must be documented in "SECTION A" of the Pre-Entrance Medical Record provided by the educational institution.
- For International Students in a Health Profession Program, follow the Health Profession Programs Immunization Guidelines.

Immunizations That Are REQUIRED Pursuant to NC State Law

**Students 17 years of age or younger.................................REQUIRED:**
- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one TD booster must have been within the past 10 years.
- 3 Polio (oral) doses
- 2 Measles (Rubeola), 1 Mumps, 1 Rubella (MMR is preferred vaccine) or positive blood titers for Measles, Mumps and Rubella.
- Tuberculin skin test with negative result within the 12 months preceding the first day of classes (chest x-ray with negative result required if skin test positive, or documentation of Tuberculosis vaccination.)

**Students 18 years of age and older.................................REQUIRED:**
- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one TD booster must have been within the past 10 years.
- 2 Measles (Rubeola), 1 Mumps, 1 Rubella (MMR is preferred vaccine) or positive blood titers for Measles, Mumps and Rubella.
- Tuberculin skin test with negative result within the 12 months preceding the first day of classes (chest x-ray with negative result required if skin test positive, or documentation of Tuberculosis vaccination.)
GUIDELINES FOR COMPLETING IMMUNIZATION RECORD FOR INTERNATIONAL STUDENTS

IMPORTANT

Tuberculin skin test with negative result within the 12 months preceding the first day of classes (chest x-ray with negative result required if skin test positive, or documentation of Tuberculosis vaccination.)

Students 18 years of age and older..........................................REQUIRED:
FTCC Form P-11 Revised 10/20/2011
For International Students in a Health Profession Program, follow the Health Profession Programs Immunization Guidelines.

Students 17 years of age or younger......................................REQUIRED:
3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one TD booster must have been within the past 10 years.
Records must be documented in black INK and all corrections must be signed.
All dates must include month, day and year of administration.
Immunizations required for the appropriate age group as outlined below must be documented in “SECTION A” of the Pre-Entrance Medical Record provided by the educational institution.
3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one TD booster must have been within the past 10 years.
3 Polio (oral) doses
2 Measles (Rubeola), 1 Mumps, 1 Rubella (MMR is preferred vaccine) or positive blood titers for Measles, Mumps and Rubella.
2 Measles (Rubeola), 1 Mumps, 1 Rubella (MMR is preferred vaccine) or positive blood titers for Measles, Mumps and Rubella.

Tuberculin skin test with negative result within the 12 months preceding the first day of classes (chest x-ray with negative result required if skin test positive, or documentation of Tuberculosis vaccination.)
PHYSICAL EXAMINATION  (Please type or print in black ink—no white out)

(A physical exam is required for both Health Profession Program and International students.)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth (mm/dd/year)</th>
<th>Student ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Area Code/Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>TPR</th>
<th>B/P</th>
<th>/</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>VISION</th>
<th>Corrected</th>
<th>Right 20/</th>
<th>Left 20/</th>
<th>Uncorrected</th>
<th>Right 20/</th>
<th>Left 20/</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SYSTEMS REVIEW

Are there abnormalities? If so, describe fully

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>DESCRIPTION (attach additional sheets if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td>Head, Ears, Nose, Throat</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td>Eyes</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td>Respiratory</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td>Hernia</td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td>Metabolic/Endocrine</td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td>Neuropsychiatric</td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td>Skin</td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td>Mammary</td>
</tr>
</tbody>
</table>

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 Students Admitted to a Health Profession Program—Must Be Completed by Physician, PA or NP

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 Physician/Physician Assistant/Nurse Practitioner

Signature of Physician/Physician Assistant/Nurse Practitioner

Office Address

Print Name of Physician/Physician Assistant/Nurse Practitioner

Area Code/Phone Number

FTCC Form P-11

Revised 10/20/2011
PHYSICAL EXAMINATION
(Please type or print in black ink—no white out)

(A physical exam is required for both Health Profession Program and International students.)

Last Name First Name Middle Name Date of Birth (mo./day/year) Student ID Number
Permanent Address City State Zip Code Area Code/Phone Number
Height Weight TPR B/P /
VISION Corrected Right 20/ Left 20/ Uncorrected Right 20/ Left 20/

SYSTEMS REVIEW
Are there abnormalities? If so, describe fully YES NO DESCRIPTION (attach additional sheets if necessary)


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 Students Admitted to a Health Profession Program—Must Be Completed by Physician, PA or NP 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 Physician/Physician Assistant/Nurse Practitioner Date
Print Name of Physician/Physician Assistant/Nurse Practitioner
Office Address Area Code/Phone Number

HCC Form P-11 Revised 3/21/14
IMMUNIZATION RECORD (Please type or print in black ink—no white out)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth (mo./day/year)</th>
<th>Student ID Number</th>
</tr>
</thead>
</table>

**SECTION A**

**Required Immunizations For All Health Profession Program Students**
(See Enclosure “Guidelines For Completing Immunization Record For Health Profession Program Students to determine immunizations required for the student’s age.”)

<table>
<thead>
<tr>
<th>Immunization</th>
<th>#1 mo./day/year</th>
<th>#2 mo./day/year</th>
<th>#3 mo./day/year</th>
<th>#4 mo./day/year</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT or Td</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Td Booster</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap (if no tetanus immunization within the last 2 years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Rubella, Red Measles)</td>
<td>Date and Result</td>
<td>Date and Result</td>
<td>Date and Result</td>
<td>Date and Result</td>
</tr>
<tr>
<td>Mumps (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(German Measles)</td>
<td>Date and Result</td>
<td>Date and Result</td>
<td>Date and Result</td>
<td>Date and Result</td>
</tr>
<tr>
<td>Tuberculin Skin Test</td>
<td>Date Placed:</td>
<td>Date Read:</td>
<td>Date Placed:</td>
<td>Date Read:</td>
</tr>
<tr>
<td>(Within 30 days)</td>
<td>mm of Induration:</td>
<td></td>
<td>mm of Induration:</td>
<td></td>
</tr>
<tr>
<td>Chest x-ray, if positive TB Skin Test</td>
<td>Date:</td>
<td>Results:</td>
<td>Date:</td>
<td>Results:</td>
</tr>
<tr>
<td>Written TB Screening, if positive TB Skin Test</td>
<td>Date:</td>
<td>Results:</td>
<td>Date:</td>
<td>Results:</td>
</tr>
<tr>
<td>(PPD and Whole TB Screening required if positive TB Skin Test)</td>
<td>Date:</td>
<td>Results:</td>
<td>Date:</td>
<td>Results:</td>
</tr>
<tr>
<td>Hepatitis B Series</td>
<td>Date:</td>
<td>Results:</td>
<td>Date:</td>
<td>Results:</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>Date of disease is not sufficient for proof of immunity, Date and Result</td>
<td>Date of disease is not sufficient for proof of immunity, Date and Result</td>
<td>Date of disease is not sufficient for proof of immunity, Date and Result</td>
<td>Date of disease is not sufficient for proof of immunity, Date and Result</td>
</tr>
</tbody>
</table>

**SECTION B**

**Required Immunizations For All International Students**

See enclosed “Guidelines For Completing Immunization Record For International Students” to determine what immunizations are required for the student’s age. Document required immunizations, titers, x-rays and/or screenings in “Section A” above.

**SECTION C**

**Clinician Information**

Clinician Signature or Clinic Stamp ___________________________ Telephone ___________________________
Office Address ___________________________ Date ___________________________

Do Not Write In This Space

FTCC Form P-11 Revised 10/20/2011
IMMUNIZATION RECORD

(Please type or print in black ink– no white out)

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

SECTION A

Required Immunizations For All Health Profession Program Students (See Enclosure “Guidelines For Completing Immunization Record For Health Profession Program Students to determine immunizations required for the student’s age.)

mo./day/year mo./day/year mo./day/year mo./day/year

Tdap (if no tetanus immunization within the last 2 years)

Tuberculin Skin Test (Within 30 days) Date Placed:

Date Read:

mm of Induration: Chest x-ray, if positive TB Skin Test Date:

Results: Written TB Screening, if positive TB Skin Test Date:

(CXR and Written TB Screening required if positive TB Skin Test) Results:

Titer Date and Result

SECTION B

Required Immunizations For All International Students

See enclosed — Guidelines For Completing Immunization Record For International Students — to determine what immunizations are required for the student’s age. Document required immunizations, titers, x-rays and/or screenings in — Section All above.

SECTION C Clinician Information

Clinician Signature or Clinic Stamp Telephone Office Address Date

Do Not Write In This Space

Measles (MMR) (Rubeola, Red Measles)

Rubella (MMR) (German Measles)

Varicella (Chickenpox)

DPT or Td #1 #2 #3 #4

Mumps (MMR)

Hepatitis B Series Titer Date and Result

HCC Form P-11 Revised 3/21/14

Td Booster

Polio

Date of disease is not sufficient for proof of immunity.

Titer Date and Result

Titer Date and Result

Titer Date and Result
# Report of Medical History  (Please type or print in black ink)

<table>
<thead>
<tr>
<th>Last Name (print)</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Student ID #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Permanent Address</th>
<th>City, State, Zip Code</th>
<th>(Area Code) Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mo/day/year)</th>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
<th>Marital Status</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Person to Contact in Case of Emergency</th>
<th>Relationship</th>
<th>Area Code/Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address of Emergency Contact</th>
<th>City, State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

## Important Information – Please Read and Complete

**STATEMENT BY STUDENT:** I have personally supplied the above and enclosed information and attest that it is true and complete to the best of my knowledge. I understand that though the information will be treated as strictly confidential, it may be released, only as appropriate and necessary to satisfy the requirements of clinical facilities where I am assigned to participate in clinical rotation. I hereby give consent for Fayetteville Technical Community College and representatives thereof to release any contents of this health/immunization record strictly for the purpose of satisfying the above mentioned clinical facility requirements. I also consent to the release of this information to faculty members within my academic curriculum for the purpose of meeting my educational requirements. No other releases are allowed without my expressed written consent.

______________________________  ________________________  
Signature of Student or Student’s Legal Guardian if Student is a Minor  Date

FTCC Form P-11  Revised 10/20/2011
Report of Medical History (Please type or print in black ink)

Last Name (print) First Name Middle Name Student ID #
Permanent Address City, State, Zip Code (Area Code) Phone Number
Date of Birth (mo/day/year) Gender Male Female Marital Status
Name of Person to Contact in Case of Emergency Relationship Area Code/Phone Number
Address of Emergency Contact City, State Zip Code

Important Information – Please Read and Complete

STATEMENT BY STUDENT: I have personally supplied the above and enclosed information and attest that it is true and complete to the best of my knowledge. I understand that though the information will be treated as strictly confidential, it may be released, only as appropriate and necessary to satisfy the requirements of clinical facilities where I am assigned to participate in clinical rotation. I hereby give consent for Halifax Community College and representatives thereof to release any contents of this health/immunization record strictly for the purpose of satisfying the above mentioned clinical facility requirements. I also consent to the release of this information to faculty members within my academic curriculum for the purpose of meeting my educational requirements. No other releases are allowed without my expressed written consent.

Signature of Student or Student’s Legal Guardian if Student is a Minor Date

HCC Form P-11 Revised 3/21/14