# 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.)

## Immunizations That Are REQUIRED Pursuant to NC State Law

# GUIDELINES FOR COMPLETING IMMUNIZATION RECORD FOR INTERNATIONAL STUDENTS

## IMPORTANT

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**Students 18 years of age and older.....REQUIRED:**

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For International Students in a Health Profession Program, follow the Health Profession Programs Immunization Guidelines.

**Students 17 years of age or younger.....REQUIRED:**

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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.

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# 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) |
|---|---|---|---|
| 1. Head, Ears, Nose, Throat | ☐ | ☐ | |
| 2. Eyes | ☐ | ☐ | |
| 3. Respiratory | ☐ | ☐ | |
| 4. Cardiovascular | ☐ | ☐ | |
| 5. Gastrointestinal | ☐ | ☐ | |
| 6. Hernia | ☐ | ☐ | |
| 7. Metabolic/Endocrine | ☐ | ☐ | |
| 8. Musculoskeletal | ☐ | ☐ | |
| 9. Neuropsychiatric | ☐ | ☐ | |
| 10. Skin | ☐ | ☐ | |
| 11. 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 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

# 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)**

**1. Head, Ears, Nose, Throat 2. Eyes 3. Respiratory 4. Cardiovascular 5. Gastrointestinal 6. Hernia 7. Metabolic/Endocrine 8. Musculoskeletal 9. Neuropsychiatric 10. Skin 11. 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 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**

# 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 |
|---|---|---|---|---|
| • DPT or Td | #1 | #2 | #3 | #4 |
| • Td Booster | | | | |
| • Tdap (if no tetanus immunization within the last 2 years) | | | | |
| • Polio | | | | |
| • Measles (MMR) (Rubeola, Red Measles) | | | | Titer Date and Result |
| • Mumps (MMR) | | | | Titer Date and Result |
| • Rubella (MMR) (German Measles) | | | | Titer Date and Result |
| • 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: | | | | |
| • Hepatitis B Series | | | | Titer Date and Result |
| • Varicella (Chickenpox) | | | *Date of disease is not sufficient for proof of immunity.* | 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 A" above.**

## SECTION C — Clinician Information

Clinician Signature or Clinic Stamp _____ Telephone _____

Office Address _____ Date _____

**Do Not Write In This Space**

# 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 A‖ 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**



**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)

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 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

# 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