



Joseph G. Gordon Student Health Center

Dear Students,

Welcome to Saint Augustine's College in Raleigh, North Carolina! The Joseph G. Gordon Student Health Center provides a variety of health care services to full-time students. Students may receive acute and chronic illness care, health promotion education, disease prevention education, and a full range of other primary care services from our nurse, family nurse practitioner, and physician. Mental health and counseling services are offered through the CAPS (Counseling and Psychological Services) program. Our goal is to maintain health, promote wellness, and provide nurturance for the mind and body.

In order to provide health care services and comply with North Carolina General Statutes, the Joseph G. Gordon Student Health Center requires submission of your health information as soon as possible:

- ❖ The medical history and physical examination form
 - Part A – medical history
 - Part B – immunization/shot record and physical examination
- ❖ The data sheet form.

Your health information should be mailed or faxed to the student health center. If your health information is submitted before the deadline (**July 15th for fall admission and December 15th for spring admission**), you will receive notification of your medical clearance to register for classes via mail.

Joseph G. Gordon Student Health Center
1315 Oakwood Avenue
Raleigh, NC 27610
919-516-4195 (fax)

Again, the staff at Joseph G. Gordon Student Health Center looks forward to assisting with your health care needs. If you have any questions, please call 919-516-4142.

Regards,

A handwritten signature in cursive script that reads "Pam Douglas".

Pamela Douglas
Administrative Assistant of Joseph G. Gordon Student Health Center





Joseph G. Gordon Student Health Center

Medical History and Physical Examination

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INSTRUCTIONS

According to North Carolina General Statute (G.S. 130A – 155.1), every student must complete immunization shots to attend college courses or live on campus. Students are also required to have a physical and tuberculosis skin test.

"...no person shall attend a college or university, whether public, private, or religious, unless a certificate of immunization or a record of immunization from a high school North Carolina indicating that the person has received immunizations required by G.S.130-152 is presented to the college or university...The person shall have thirty calendar days from the date of the person's first registration to obtain the required immunization...Upon termination of this time period, the college or university shall not permit the person to continue in attendance unless the required immunization has been obtained..."

1. Students and/or parents complete **PART A**. The medical history will allow us to provide better care for the student.
2. A health care provider (physician, nurse practitioner, or physician assistant) will need to complete **PART B**. The physical examination will need to occur before the student's matriculation. We can not accept physical examinations that were performed more than one year ago. Students admitted for the Fall Semester, should have their physical examination completed anytime from August of the previous year – July of the admission year. Students admitted for the Spring Semester, should have their physical examination anytime from January of the previous year – December of the previous year. (For example, students who are admitted for Spring 2007, should have their physical examination anytime from January 2006 – December 2006. Students, who are admitted for Fall 2007, should have their physical examination anytime August 2006 – July 2007). After the physical examination, the health care provider will need to sign and date **PART B**.
 - a. If the health care provider does not have the student's shot record during the exam, parents or students will need to obtain a copy of the student's shot records.
 - b. The Tuberculin skin test/PPD (test for tuberculosis) must be performed within the past year. Tuberculin skin test older than twelve months old will not be accepted. The Tuberculin skin test section requires a placement date with health care staff's signature and a reading date with results and health care staff's signature.
3. Please mail or fax **PART A** and **PART B** directly to Joseph G. Gordon Student Health Center before **July 15 for Fall admission** and before **December 15 for Spring admission**. For students receiving a late acceptance, **PART A** and **PART B** should be mailed or faxed within ten days of your college acceptance notice. If the health care provider does not have a copy of the student's shot record, students/parents will need to obtain the shot record. Students/Parents will need to mail or fax a copy of the shot records to Joseph G. Gordon Student Health Center with **PART A** and **PART B**. Students/Parents please also keep a copy of the physical examination and shot record for your files at home.

Joseph G. Gordon Student Health Center
1315 Oakwood Avenue
Raleigh, NC 27610
919-516-4142 (phone)
919-516-4195 (fax)

PART A
Joseph G. Gordon Student Health Center

TO BE COMPLETED BY APPLICANT
(This record is a privileged communication and will be treated confidentially.)

LAST NAME (Print)	FIRST NAME	MIDDLE	SOCIAL SECURITY NUMBER
HOME ADDRESS (NUMBER & STREET)		CITY	STATE ZIP TELEPHONE NUMBER
Date of Birth: _____ Marital Status: S__ M__ Other__ Sex: M__ F__ Expected Enrollment _____ Previously Enrolled Here? _____			
Health Insurance:	Name of Company Address	Policy Number	

PARENTS OF STUDENTS UNDER 18: I authorize any medical treatment that may be advised or recommended by the medical staff for my son/ daughter.

Signature of Parent

Witness

Date

FAMILY HISTORY: INDICATE WHICH OF YOUR RELATIVES HAD ANY OF THE FOLLOWING?

CANCER _____ HIGH BLOOD PRESSURE _____ MENTAL ILLNESS _____ KIDNEY DISEASE _____
 ASTHMA _____ ARTHRITIS _____ HEART DISEASE _____ TUBERCULOSIS _____
 DIABETES _____ STROKE _____ STOMACH DISEASE _____ CONVULSIONS/ EPILEPSY _____

PERSONAL HISTORY: PLEASE EXPLAIN ALL YES ANSWERS BELOW OR ON A SEPARATE SHEET.

HAVE YOU HAD?	YES	NO		YES	NO
EYE TROUBLE			HYPO/ HYPERTENSION		
EAR, NOSE, THROAT TROUBLE			ANEMIA		
FREQUENT OR SEVERE HEADACHES			DIABETES		
CONVULSIONS/ EPILEPSY			HEPATITIS/ JAUNDICE		
ASTHMA/ HAY FEVER			HEART DISEASE		
TUBERCULOSIS			KIDNEY DISEASE		
RESPIRATORY PROBLEMS			FEMALES ONLY:		
INFECTIOUS MONONUCLEOSIS			IRREGULAR PERIODS		
STOMACH/ INTESTINAL PROBLEMS			SEVERE CRAMPS		
DISEASE OR INJURY OF BONES OR JOINTS			EXCESSIVE FLOW		

1. Please list any past or present illnesses/ hospitalizations. (Physical or emotional) _____
2. Are you currently being treated for any conditions? (If so please explain) _____
3. Please list names and addresses of physicians who are currently treating the conditions listed above. _____
4. Please list any prescribed medications that you are currently taking. _____
5. Are you allergic to any drugs, foods, etc. (please list). _____

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 knowledge and written consent. However, if I should be ill or injured and unable to sign the appropriate forms, I hereby authorize the Joseph G. Gordon Student Health Center to release information from my medical record to a physician, hospital or other medical agency involved in giving me emergency treatment.

Student Signature

Date

Parent or Guardian Signature (if student age 17 or younger)

Date

PART B
Joseph G. Gordon Student Health Center

TO BE COMPLETED BY HEALTH CARE PROVIDER
(This record is a privileged communication and will be treated confidentially.)

STUDENT'S LAST NAME FIRST NAME MIDDLE NAME DATE OF BIRTH

The state of North Carolina requires all students entering college to submit a valid copy of their immunization records to the college in order to register. (A valid copy may be obtained from your high school, family physician, health department, clinics, or other colleges you have attended). All shot records require verification by a doctor's stamp or signature or a clinic or health department stamp.

IMMUNIZATIONS	DATE	DATE	DATE
DTP/ DTP/ TD (ONE MUST BE WITHIN THE LAST 10 YEARS). Series of 3 required.			
Td Booster within the last 10 years.			
Polio, Series of 3 (not required after age 17)			
MMR (measles, mumps, rubella) Series of 2 required.			
Hepatitis B (Recommended, not required)			
Meningitis Vaccine (Recommended, not required)			
Tuberculin Skin Test (within the last year)	Date given: _____ Signature: _____	Date Read: _____ Results: _____ mm Signature: _____	
Chest X-ray (if applicable)	Date given: _____	Results: _____ (attach a copy of the chest x-ray report to form)	

Health Care Staff Signature _____ Office Stamp _____

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

Height _____ inches	Weight _____ lbs	B/P _____	Pulse _____	Hearing (gross) Right _____ Left _____
Corrected Vision: Right 20/ _____ Left 20/ _____		Uncorrected Vision: Right 20/ _____ Left 20/ _____		
Urinalysis: Glucose _____	Ketones _____	Leukocytes _____	Blood _____	Protein _____ HGB/HCT _____ / _____
Are there any abnormalities ?	Normal	Abnormal	Description (attach additional sheets if necessary)	
1. Head, Ears, Nose, Throat				
2. Eye				
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 organ? Yes No
 Explain: _____
- B. Is the student under treatment for any medical or emotional condition? Yes No
 Explain: _____
- C. Recommendations for physical activity (Phys. Ed., Intercollegiate, Intramurals, etc.)
 Unlimited Limited Explain: _____
- D. Significant findings or general comments regarding this student. Is student physically and emotionally healthy?
 Explain: _____

Signature of Physician/ Physician's Assistant/ /Nurse Practitioner _____

Physical Examination Date _____

Signature of Physician/ Physician's Assistant/ /Nurse Practitioner _____

Area Code/ Phone Number _____

Office Address/ Stamp City State Zip Code

Area Code/ Phone Number _____



Joseph G. Gordon Student Health Center

DATA SHEET

Instructions: Please print the requested information

Student's Name _____ Date of Birth _____
(Last) (First) (Middle)

Social Security Number _____ Home Phone Number _____
(Area Code) Phone Number

Student's Cellular Phone Number _____ Allergies _____
(Area Code) Phone Number

Parents' or Guardians' Name _____
(Mother's Name – Last, First)

(Father's Name – Last, First)

Permanent Address _____
(Street) (City) (State) (Zip Code)

Emergency Contact Person _____
(Last Name) (First Name)

Emergency Contact's Home Phone Number _____ Cellular/Work Number _____
(Area Code) Phone Number (Area Code) Phone Number

Student's Medical Insurance Company _____

Company / Claim Address _____
(Street or P.O. Box) (City) (State) (Zip Code)

Company Phone Number _____
(Area Code) Phone Number

Policy Holder's Name _____

Subscriber or Policy Number _____

Group Number _____

Co-Pay or Deductible for Primary Care Provider/Physician _____ Specialist _____

Student Signature _____ Date _____

Parent or Guardian Signature _____ Date _____
(if student is 17 years old or younger)