Dear Applicant,

Welcome to Saint Augustine’s University in Raleigh, North Carolina! The Joseph G. Gordon Health Center provides a variety of health care services to full-time students. In order to provide health care services and comply with the North Carolina General Statutes, the Joseph G. Gordon Health Center requires submission of your health information as soon as possible. The deadline for submission of all health documents are July 15th for fall admission and December 15th for spring admission. If required documents are not in our files, students will not be cleared and will not be able to register for classes until they are submitted.

Required Health Documents: <Forms are attached>

1. Part A – Medical History (Applicant completes).
2. Part B – Physical Examination (Health Care Provider completes).
   *Exam must be within one (1) year of admission date.
3. Proof of Immunizations: (Due to the NC State Law record of Immunizations cannot be accepted on a school transcript).
   - Three (3) DPT vaccinations – last vaccine must be within 10 years of admission.
   - Two (2) MMR vaccinations.
   - Three (3) Polio vaccinations (for applicants under age 18 at time of admission).
   - Three (3) Hepatitis B vaccinations (if born after July 1, 1994)
4. Tuberculosis (TB) Screening Questionnaire/Risk Assessment
5. Personal Data Sheet (Applicant completes).

*Please be sure to keep a copy of all documents submitted (especially your physical and shot records) for your files at home.

Your health documents should be mailed or faxed to:
Joseph G. Gordon Health Center
1315 Oakwood Avenue
Raleigh, NC 27610
919-516-4195 (fax)

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

Regards,
Gordon Health Center Staff
TO BE COMPLETED BY APPLICANT
(This record is a privileged communication and will be treated confidentially.)

LAST NAME    FIRSTNAME    MIDDLE    DATE OF BIRTH

HOME ADDRESS (NUMBER & STREET)    CITY    STATE    ZIP    TELEPHONE NUMBER

Marital Status: S__ M__ Other__ Sex: M__ F__ Expected Enrollment ___________ Previously Enrolled Here? ___________

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                                           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 OF PAPER.

HAVE YOU HAD?                   YES   NO                        YES   NO

EYE TROUBLE
EAR, NOSE, THROAT TROUBLE
FREQUENT OR SEVERE HEADACHES
CONVULSIONS/ EPILEPSY
ASTHMA/ HAY FEVER
TUBERCULOSIS
RESPIRATORY PROBLEMS
INFECTION MONONUCLEOSIS
STOMACH/ INTESTINAL PROBLEMS
DISEASE OR INJURY OF BONES OR JOINTS

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 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

Rev. 8/1/12
PART B - PHYSICAL EXAMINATION
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.

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP/ DPT/ TD (ONE MUST BE WITHIN THE LAST 10 YEARS).</td>
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<tr>
<td>Series of 3 required.</td>
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<tr>
<td>Td Booster within the last 10 years.</td>
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<tr>
<td>Polio, Series of 3 (not required after age 17)</td>
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<tr>
<td>MMR (measles, mumps, rubella) Series of 2 required.</td>
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<tr>
<td>Hepatitis B (Series of 3, if born after July 1, 1994)</td>
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<tr>
<td>Meningitis Vaccine (Recommended, not required)</td>
<td></td>
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<tr>
<td>Tuberculin Skin Test (within the last year)</td>
<td>Date given:</td>
<td>Date Read:</td>
<td>Results:</td>
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<td></td>
<td>Signature:</td>
<td>mm</td>
<td></td>
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<tr>
<td>Chest X-ray (if applicable)</td>
<td>Date given:</td>
<td>Results:</td>
<td>(attach a copy of the chest x-ray report to form)</td>
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</tbody>
</table>

Health Care Staff Signature _______________________ Office Stamp _______________________

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>lbs</th>
<th>B/P</th>
<th>Pulse</th>
<th>Hearing (gross)</th>
<th>Right</th>
<th>Left</th>
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</thead>
<tbody>
<tr>
<td>Corrected Vision:</td>
<td>Right 20/</td>
<td>Left 20/</td>
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<tr>
<td>Urinalysis:</td>
<td>Glucose</td>
<td>Ketones</td>
<td>Leukocytes</td>
<td>Blood</td>
<td>Protein</td>
<td>HGB/HCT</td>
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<tr>
<td>Are there any</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Description (attach additional sheets if necessary)</td>
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</tr>
<tr>
<td>1. Head, Ears, Nose, Throat</td>
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<td>2. Eye</td>
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<td>3. Respiratory</td>
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<td>4. Cardiovascular</td>
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<td>5. Gastrointestinal</td>
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<td>6. Hernia</td>
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<td>7. Genitourinary</td>
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<td>8. Musculoskeletal</td>
<td></td>
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<td>9. Metabolic/ Endocrine</td>
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<td>10. Neuropsychiatric</td>
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<tr>
<td>11. Skin</td>
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<tr>
<td>12. Mammary</td>
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</tbody>
</table>

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 ___________________________

Office Address/ Stamp ___________________________ City ___________________________ State ___________________________ Zip Code ___________________________ Area Code/ Phone Number ___________________________
Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

1. Have you ever had a positive TB skin test? Yes  No
2. Have you ever had close contact with anyone who was sick with TB? Yes  No
3. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? * (If yes, please CIRCLE the country) Yes  No

4. Have you ever traveled** to/in one or more of the countries listed below? (If yes, please CHECK the country/ies) Yes  No

5. Have you ever been vaccinated with BCG? Yes  No

*future CDC updates may eliminate the 5 year time frame
**The significance of the travel exposure should be discussed with a health care provider and evaluated.


Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp

Low risk- if answers to all questions are NO, no further testing or further action required.

High risk- if answer YES to any of the above questions, St. Augustine’s University requires that a health care provider complete a tuberculosis risk assessment (on back or attached) prior to start of classes.

Health Care Provider Signature ___________________________ Date ________________

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Tuberculosis (TB) Risk Assessment

Persons with any of the following are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

### Risk Factor

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent close contact with someone with infectious TB disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign-bred from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease</td>
<td></td>
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<tr>
<td>HIV/AIDS</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Organ transplant recipient</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Immunosuppressed (equivalent of &gt; 15 mg/day of prednisone for &gt;1 month or TNF-α antagonist)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>History of illicit drug use</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin’s disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)] Yes No

*The significance of the travel exposure should be discussed with a health care provider and evaluated.*

1. Does the student have signs or symptoms of active tuberculosis disease?  Yes ______  No ______

If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.)*

<table>
<thead>
<tr>
<th>Date Given: <em><strong><strong>/</strong></strong></em>/______</th>
<th>Date Read: <em><strong><strong>/</strong></strong></em>/______</th>
</tr>
</thead>
<tbody>
<tr>
<td>M    D    Y</td>
<td>M    D    Y</td>
</tr>
</tbody>
</table>

Result: ________ mm of induration  **Interpretation:  positive____ negative____
PERSONAL DATA SHEET

Instructions: Please print and complete all of the requested information.

Student’s Name___________________________________ Date of Birth______ / ____ / ______

Social Security Number ___________________________ Home Phone Number____________________

Student’s Cellular Phone Number_________________________ Allergies____________________

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 # __________________________ Cellular/Work # __________

(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)