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

SAINT AUGUSTINE'S UNIVERSITY
Joseph G. Gordon Health Center

PART A – MEDICAL HISTORY

Please Print Clearly

For office use only!

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			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 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**

SAINT AUGUSTINE'S UNIVERSITY
Joseph G. Gordon Health Center

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.

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 (Series of 3, if born after July 1, 1994)			
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 **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	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**

_____ _____

Office Address/ Stamp City State Zip Code Area Code/ Phone Number

SAINT AUGUSTINE'S UNIVERSITY
Joseph G. Gordon Health Center

Student Name: _____ Date of Birth: _____/_____/_____

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.*

Afghanistan	Congo DR	Kenya	New Caledonia	Sri Lanka
Algeria	Cote d'Ivoire	Kiribati	Nicaragua	Sudan
Angola	Croatia	Korea-DPR	Niger	Suriname
Anguilla	Djibouti	Korea-Republic	Nigeria	Syrian Arab Republic
Argentina	Dominican Republic	Kuwait	Niue	Swaziland
Armenia	Ecuador	Kyrgyzstan	N. Mariana Islands	Tajikistan
Azerbaijan	Egypt	Lao PDR	Pakistan	Tanzania-UR
Bahamas	El Salvador	Latvia	Palau	Thailand
Bahrain	Equatorial Guinea	Lesotho	Panama	Timor-Leste
Bangladesh	Eritrea	Liberia	Papua New Guinea	Togo
Belarus	Estonia	Lithuania	Paraguay	Tokelau
Belize	Ethiopia	Macedonia-TFYR	Peru	Tonga
Benin	Fiji	Madagascar	Philippines	Tunisia
Bhutan	French Polynesia	Malawi	Poland	Turkey
Bolivia	Gabon	Malaysia	Portugal	Turkmenistan
Bosnia & Herzegovina	Gambia	Maldives	Qatar	Tuvalu
Botswana	Georgia	Mali	Romania	Uganda
Brazil	Ghana	Marshall Islands	Russian Federation	Ukraine
Brunei Darussalam	Guam	Mauritania	Rwanda	Uruguay
Bulgaria	Guatemala	Mauritius	St. Vincent & The Grenadines	Uzbekistan
Burkina Faso	Guinea	Mexico		Vanuatu
Burundi	Guinea-Bissau	Micronesia	Sao Tome & Principe	Venezuela
Cambodia	Guyana	Moldova-Rep.	Saudi Arabia	Viet Nam
Cameroon	Haiti	Mongolia	Senegal	Wallis & Futuna Islands
Cape Verde	Honduras	Montenegro	Seychelles	W. Bank & Gaza Strip
Central African Rep.	India	Morocco	Sierra Leone	Yemen
Chad	Indonesia	Mozambique	Singapore	Zambia
China	Iran	Myanmar	Solomon Islands	Zimbabwe
Colombia	Iraq	Namibia	Somalia	
Comoros	Japan	Nauru	South Africa	
Congo	Kazakhstan	Nepal	Spain	

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 _____

SAINT AUGUSTINE'S UNIVERSITY
Joseph G. Gordon Health Center

Student Name: _____ Date of Birth: _____/_____/_____

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

Date Given:____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

SAINT AUGUSTINE'S UNIVERSITY
Joseph G. Gordon Health Center

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**_____
(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 #_____ 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)