



CATAWBA
COLLEGE

PROCTOR STUDENT HEALTH CENTER

CHECKLIST

-----REQUIRED-----

1 – PERSONAL HEALTH HISTORY
Attached Form

2 – IMMUNIZATION RECORDS
Attached Form or Official Immunization Record Accepted

3 – HEALTH INSURANCE CARD
Copy Front and Back

4 – COVID-19 VACCINATION
Official COVID Vaccination Card Required

To: New Students and Parents or Legal Guardians

From: Catawba College Proctor Foundation Health

Services Center Teresa Bivins, RN; Email:

tjbivins17@catawba.edu

Phone: 704-637-4404

Fax: 704-637-4234

Welcome and congratulations on your acceptance to Catawba College. We look forward to meeting you and managing your health care while you are a student on our campus. Catawba College is interested in every aspect of student life. An active Health Services Center is available and every effort is made to provide excellent health care. Some of our services are:

1. Management of acute problems by nurses in the Health Center, and easy access to physician care when needed.
2. Over the counter medication provided at NO cost to the student.
3. In clinic and outside laboratory testing available.

The Health Center is open Monday through Friday from 8 a.m. - 4:00 p.m.

Coverage after hours, on weekends and holidays is handled by Novant Health Urgent Care, Pro-Med Urgent Care, Fast-Med Urgent Care or through the Emergency Department at Novant Health Rowan Regional Medical Center. There will be a charge for services rendered at these facilities.

*Attached is the State of NC and Catawba College Immunization requirements for all students. The immunization form or your official immunization record must be submitted BEFORE you arrive on campus.

*Also attached is the Catawba College personal health history form that is required for all students. The form is to be completed and signed by the student or parent if student is under the age of 18.

Catawba College also requires that all students have health insurance. A copy of your insurance card is required in the Health Center as well as being on file in the Business Office. For your benefit, if you have an HMO Insurance, please contact your insurance company to request "guesting privileges".

CATAWBA COLLEGE DOES NOT ACCEPT OUT OF STATE MEDICAID OR INTERNATIONAL HEALTH INSURANCE POLICIES

Please return the required forms and a copy of your insurance card to the Proctor Health Center NO LATER THAN 30 DAYS PRIOR TO ENROLLMENT to:

1. Email to healthcenter@catawba.edu
2. Fax to 704-637-4234
3. Mail to:
Proctor Student Health Center
2300 West Innes St.
Salisbury, NC 28144

It is required by North Carolina State Law (General Statutes 130A-157, as amended effective July 1, 1994) that this form be on file at the Catawba College Health Services Center BEFORE registration. Students not satisfactorily meeting immunization requirements will be subject to suspension from Catawba College.

THIS FORM MUST BE
COMPLETED AND RETURNED
NO LATER THAN 30 DAYS
PRIOR TO ENROLLMENT.

Catawba College
Health History
to be completed by Student

For Office Use Only
completed _____
2 week letter _____
insurance _____
NCIR _____

Please answer all questions. Print or type

Name _____ Sex _____ Age _____ Birth Date _____

Last
First
Middle

Home Address _____ Phone _____

Street
City
State
Zip

Marital Status: S M W D Student ID _____ Student's Cell Number _____

Student's Personal E-Mail Address: _____

A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD MUST ACCOMPANY THIS FORM.

HOSPITAL/ HEALTH INSURANCE: Student must be covered with personal or school insurance

INSURANCE COVERAGE MANDATORY Personal _____ School _____

<p style="text-align: center; margin: 0;">CLASS YOU ARE ENTERING</p> <p style="margin: 0;"><input type="checkbox"/> Freshman <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior</p>	<p style="text-align: center; margin: 0;">PREVIOUSLY ENROLLED</p> <p style="margin: 0;"><input type="checkbox"/> No <input type="checkbox"/> Yes Date(s) _____</p>	<p style="text-align: center; margin: 0;">PROPOSED REGISTRATION</p> <p style="margin: 0;"><input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Summer 20____</p>
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PERSONAL HISTORY: In order to better facilitate student care, please answer if you have ever had any of the following:

	YES	NO		YES	NO		YES	NO
Arthritis			Rheumatic Fever			Ear, Nose, Throat Trouble		
Migraine			Heart Disease or Murmur			Anorexia Nervosa/ Bulimia		
Epilepsy (convulsive disorder)			High Blood Pressure			Hepatitis		
Asthma, Hayfever, Hives			Tuberculosis			Kidney Disease		
Other Allergic Conditions			Diabetes			Gastrointestinal Conditions		
Mononucleosis			Emotional Condition			COVID-19 Vaccine		

Other serious illnesses / hospitalizations / injuries / disabilities / deformities: _____

If any of the above are YES, give details: _____

Any medical condition which will interfere with regular physical education or athletic participation?
 If so, what? _____
 Give name(s) and address(es) of doctor(s) and/ or hospital(s) or clinic(s): _____

Any emotional condition, give name(s) and address(es) of doctor(s) and/ or hospital(s) or clinic(s): _____

PRESENT ILLNESS: Any disease, drug or treatment that should be continued or evaluated periodically? Yes No If yes, please explain: _____

DRUG ALLERGIES: Yes No If yes, what drugs? _____

EMERGENCY INFORMATION: In case of emergency, please notify: _____

Name
Address

 Relationship _____ Phone _____ Email _____

PARENT/ GUARDIAN of students under 18: I hereby authorize any medical treatment for my child which may be advised or recommended by the medical staff of the Catawba College Student Health Center.

Signature of Parent/ Guardian: _____ Date _____

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 hereby give my permission to any doctor, hospital, or other medical agency to release confidentially to the Student Health Center Physician(s) of Catawba College any information they may have concerning my medical condition and their professional contact with me.

Signature of Student: _____ Date _____

Name _____

Proctor Student Health Center:

DOB _____

Catawba College IMMUNIZATION HISTORY- Part I

A - H Mandatory

N.C. STATE LAW REQUIRES THAT ANY STUDENT NOT PRESENTING PHYSICIAN-SIGNED IMMUNIZATION MUST BE IMMUNIZED DURING THE INITIAL 30 DAY OF THE SEMESTER. NON-COMPLIANCE REQUIRES REMOVAL FROM SCHOOL. COPIES OF THE N.C. HIGH SCHOOL IMMUNIZATION CERTIFICATION OR OFFICIAL DOCUMENTATION ARE ACCEPTABLE IF UP-TO-DATE.

A. TETANUS-DIPHtherIA

SERIES OF THREE DATES:

Tetanus-Pertussis-Diphtheria
(most recent dose must be within last ten years)

[] [] []
(MO) (DAY) (YR)

[] [] []
(MO) (DAY) (YR)

[] [] []
(MO) (DAY) (YR)

-AND-

Tdap (one lifetime dose)

Date of Tdap Vaccination:

[] [] []
(MO) (DAY) (YR)

B. MEASLES, MUMPS, RUBELLA (MMR) - TWO DOSES REQUIRED

Dose 1 - 4 days prior to or on 1st birthday

Date of Vaccination:

[] [] []
(MO) (DAY) (YR)

-AND-

Dose 2 - At least one month after 1st dose

Date of Vaccination:

[] [] []
(MO) (DAY) (YR)

IF MMR NOT GIVEN, PROCEED TO C, D AND E.

C. MEASLES (RUBEOLA) Check one (not required if born before 1/1/57)

1. Two does required

Date of Vaccination:

Dose 1-Immunization on or after 1st birthday

[] [] []
(MO) (DAY) (YR)

-AND-

Date of Vaccination:

[] [] []
(MO) (DAY) (YR)

Dose 2-At least one month after 1st dose

Date of Disease:

[] [] []
(MO) (DAY) (YR)

2. Had disease; confirmed by office record

Date of Titer:

-OR-

[] [] []
(MO) (DAY) (YR)

3. Report of positive immune titer

[] [] []
(MO) (DAY) (YR)

D. RUBELLA - History of disease is NOT acceptable verification. Check one (not required if 50 years old or older)

1. Immunization on or after 1st birthday

Date of Vaccination:

[] [] []
(MO) (DAY) (YR)

-OR-

Date:

2. Has report of positive immune titer

[] [] []
(MO) (DAY) (YR)

E. MUMPS - Check one (not required if born before 1/1/57)

Date of Vaccination:

1. Immunization on or after 1st birthday

[] [] []
(MO) (DAY) (YR)

-OR-

Date of Disease:

2. Had disease; confirmed by office record

[] [] []
(MO) (DAY) (YR)

F. POLIO -

1. Completed primary series No Yes; Type of vaccine OPV IPV

Last Booster Date:

[] [] []
(MO) (DAY) (YR)

G. HEPATITIS B SERIES OF THREE DATES

(Not required if born before July 1, 1994)

Dates: # 1

[] [] []
(MO) (DAY) (YR)

2

[] [] []
(MO) (DAY) (YR)

3

[] [] []
(MO) (DAY) (YR)

H. VARICELLA - Required if born on/after April 1, 2001.

Dates: #1

[] [] []
(MO) (DAY) (YR)

#2

[] [] []
(MO) (DAY) (YR)

MANDATORY PHYSICIAN INFORMATION

PHYSICIAN'S NAME _____
(Print or Type) Physician's Signature

ADDRESS _____
Street Address City State Zip

PHONE NUMBER _____ DATE _____

IMMUNIZATION HISTORY - Part II (Catawba Required)

COVID-19 VACCINE*
(Required)
Pfizer, BioNTech, or Moderna Date: _____ Date _____

Johnson & Johnson/Janssen Date: _____

**Please submit record of vaccination to healthcenter@catawba.edu.*

IMMUNIZATION HISTORY - Part III (Strongly Recommended)

MENINGITIS VACCINE Date: _____
(Recommended, not mandatory)

HEPATITIS A Dates #1 _____ #2 _____

HPV Dates: #1 _____ #2 _____ #3 _____



PLEASE SUBMIT COMPLETED FORM 30 DAYS PRIOR TO ENROLLMENT.