The Univeristy of North Carolina at Chapel Hill
Health Information Management
CB# 7470,Chapel Hill, NC 27599
919-966-2283 campushealth.unc.edu

Thank you for completing your Immunization and Health History Form!

Please follow the directions below to submit your form via ConnectCarolina. **Your must submit your form via ConnectCarolina. Campus Health Services will not accept hard copy, faxed, or emailed forms.**

1. Have your local health care provider sign the printed form to verify all immunization dates on the form OR you may attach copies of a verified certificate of immunization (see below for requirements) in lieu of getting a health care provider signature.
   *****A verified certificate of immunization must include the name, address, sex, and date of birth of the student. The certificate must also include the name, number of doses, and the dates of all vaccines given as well as the name and address of the medical provider, clinic or local health department administering the required immunizations. If the immunization certificate is coming from a previous school, we can accept the record if the school stamps the record with their official seal/stamp.
2. Sign the Patient Agreement and complete the TB Screening form that prints with the Immunization and Health History Form.
3. Upload all completed and signed documents as a single file **BY JUNE 15th** into the To Do List item on your Student Services page in ConnectCarolina (accepted file formats are .pdf and .tiff) *please note there is a 5mb size limit.
4. If you are missing vaccine requirements, an additional To Do list item will be added to your account indicating what requirement have not been met.

Please note that YOU WILL BE WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if the immunization requirements are not been met per North Carolina state law. For more information, please call 919-966-2283, email immunizations@unc.edu or visit https://campushealth.unc.edu/services/immunizations.

Quick Steps to Upload the Immunization and Health History Form

1. Log in to your ConnectCarolina Student Center.
2. Click on the General Items link under the To Do List box on the right side of the page.
3. Under your General To Do Items, Click on the Immunization Health History link.
4. To upload your Immunization and Health History Form, click the “Add” button located under Upload File at the bottom of the page.
5. This will open up the “File Attachment” dialog box. Please Note: Make sure you have disabled any pop-up blockers within your browser
6. Within this window, click the "Browse" button to search for the appropriate file on your computer. **To upload a document, it must be in PDF or .tiff file format (5mb size limit) and all pages for that particular checklist item must be saved in one PDF or .tiff file.** Once you have located and selected your document, click the "Upload” button.
7. Verify that the file name now displays under Upload File.
8. If you did not upload the correct file, you can click the “Delete” button to remove the existing file, and upload a new file. You can also click the “View” button to view the uploaded document.
9. When you are ready to submit your Immunization Health History form, click the “Submit” button at the bottom of the page.
10. You will then be directed to the “Thank you for completing this item” page. Click the “Return to Student Center” button to return to your Student Center.
11. Your Immunization Health History To Do item will be completed and removed from your General Items list. If further documentation is required, a new To Do List item will be added to your General Items.

If you have questions regarding uploading your Immunization and Health History Form, please contact the UNC Help desk at http://help.unc.edu/ for live chat or call 919-962-HELP (4357).

*****INFORMATION ONLY – DO NOT UPLOAD THIS PAGE WITH YOUR HEALTH HISTORY FORM*****

JAMES A. TAYLOR CAMPUS HEALTH SERVICES

The University of North Carolina at Chapel Hill ▪ CB# 7470 ▪ Chapel Hill, NC 27599-7470 Fax: 919-966-0616 Email: Immunizations@unc.edu

REPORT OF MEDICAL HISTORY

GOEKE	ERIN		730203991
LAST NAME (print)	FIRST NAME	MIDDLE/MAIDEN NAME	PERSONAL ID#(PID)

3017 Havasu Way	High Point	NC	27265	
PERMANENT ADDRESS	CITY	STATE	ZIP CODE	COUNTRY

DATE OF BIRTH (MM/DD/YYYY) 12/08/1998 GENDER ☐ M ☒ F ☐ T PREFERRED PRONOUN _____ MARITAL STATUS ☒ S ☐ M

UNC EMAIL eggoeke@live.unc.edu PHONE: Cell: 336 Home: 8842644

Year Entering: 2017 Semester Entering: ☒ Fall ☐ Spring ☐ Summer 1 ☐ Summer 2

Class Entering: ☒ First Year. ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Professional

Program: ☐ Medical ☐ Dental ☐ Nursing ☐ Pharmacy ☐ Allied Health ☐ Law ☐ Social Work ☐ Other: _____

Previously enrolled at another University? ☒ No ☐ Yes If Yes, Dates of Enrollment_____

If previously enrolled at UNC – Chapel Hill, Dates of Enrollment:_____

International Student: ☒ No ☐ Yes If yes, Country of Origin_____ Primary Language: _____

John Goeke		Father
NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY		RELATIONSHIP

3017 Havasu Way	High Point	NC	27265	3366875952
ADDRESS	CITY	STATE	ZIP CODE	AREA CODE/PHONE NUMBER

FAMILY & PERSONAL HEALTH HISTORY

Has any person, related by blood, had any of the following:

	Yes	No	Unknown
Alcohol/drug problems	X		
Blood or clotting disorder		X	
Cancer (type)		X	
Cholesterol or blood fat disorder		X	

	Yes	No	Unknown
Diabetes		X	
Glaucoma		X	
Heart attack before age 55		X	

	Yes	No	Unknown
High blood pressure		X	
Psychiatric illness	X		
Stroke		X	
Suicide	X		

HEIGHT 69 WEIGHT 154

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
ADD/ADHD		X	
Alcohol use		X	
Allergy injection therapy		X	
Anemia or Sickle Cell Anemia		X	
Anorexia		X	
Arthritis		X	
Asthma		X	
Bladder infection		X	
Blood transfusion		X	
Bone, joint, or other deformity		X	
Broken bones		X	
Bulimia		X	
Chicken Pox		X	
Chronic cough		X	
Concussion or traumatic brain injury		X	

	Yes	No	Year
Diabetes		X	
Disabling depression	X		2017
Dizziness or fainting spells		X	
Drug use		X	
Easy fatigability		X	
Epilepsy		X	
Excessive worry or anxiety	X		2017
Eye trouble besides need glasses		X	
Frequent or severe headache	X		2015
Frequent Sinus Infections		X	
Frequent vomiting		X	
Gall bladder trouble or gallstones		X	
Hay fever		X	
Head or neck radiation		X	
Hearing loss		X	

	Yes	No	Year
Heart trouble		X	
Hernia		X	
High blood pressure		X	
Intestinal trouble		X	
Irregular periods		X	
Jaundice or hepatitis		X	
Kidney infection		X	
Kidney stones		X	
Knee problems		X	
Malaria		X	
Mononucleosis		X	
Neck injury		X	
Pain or pressure in chest		X	
Paralysis		X	
Pilonidal cyst		X	
Pneumonia		X	

	Yes	No	Year
Protein or blood in urine		X	
Recurrent back pain Or back injury		X	
Regularly exercise	X		
Serious skin disease		X	
Severe menstrual cramps		X	
Severe or recurrent abdominal pain		X	
Sexually trans. disease (STD)		X	
Shortness of breath		X	
Thyroid trouble (specify)		X	
Tobacco Use		X	
Tumor or cancer (specify)		X	
Ulcer (duodenal or stomach)		X	
Ulcerative colitis,Crohn's		X	

Other (specify)

Fallopian Tube Cyst

Medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) used:

Name	Use	Dosage	Name	Use	Dosage
Zoloft	Depression	150 mg			
Wellbutrin	Depression	100 mg			
Nexplanon	Birth Control	Implant			

Adverse Reactions to:	Yes	No	Explanation
Penicillin		X	
Sulfa	X		Allergic, 10 years old, yes
Other antibiotics (name)		X	
Aspirin		X	
Codeine Other pain relievers		X	
Other drugs, medicines, chemicals (specify)		X	
Insect bites		X	
Food allergies (name)	X		Mango (Hives, 13, yes)

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)		X	
Have you ever been a patient in any type of hospital? (Specify when, where, and why)	X		Moses Cone Health, 14 y/o, fallopian tube cyst
Has your academic career been interrupted due to physical or emotional problems? (Please explain)	X		Days missed bcause of depression & cyst
Is there loss or seriously impaired function of any paired organs? (Please describe)	X		Only have one fallopian tube
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)		X	
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)		X	

Please indicate if and when you have had the following experiences: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
Received counseling for mental health concerns	X		2016
Taken a prescribed medication for mental health concerns	X		2016
Been hospitalized for mental health concerns		X	
Seriously considered attempting suicide	X		2017

	Yes	No	Year
Purposefully injured yourself without suicidal intent (e.g., cutting, hitting, burning, etc.)	X		2017
Received treatment for alcohol or drug use		X	
Someone has sexual contact with you without your consent		X	
Experienced harassing, controlling and/or abusive behavior from another person		X	

Please indicate if and how often you engaged in these behaviors in the past 30 days:

	N/A	Never	Rarely	Sometimes	Regularly	Always
Wear a seat belt when in a car						X
Eat 5 or more servings of fruits and vegetables per day				X		
Use a condom or protective barrier during sexual activity						X

Within the last 30 days, on how many days did you use:

	Never used	Have used, not in last 30 days	1-5 days	6-19 days	20+ days
Tobacco Use	X				
Alcohol (beer, wine, liquor)		X			
Marijuana (pot, weed, hashish, hash oil)		X			

UNC – CHAPEL HILL IMMUNIZATION RECORD

Last Name	First Name	Middle Name	Date of Birth (MM/DD/YYYY)	**Personal ID# (PID)**
GOEKE	ERIN		12/08/1998	730203991

SECTION A REQUIRED IMMUNIZATIONS

All students must submit documentation of 3 DTP, Td or Tdap vaccines regardless of age. One MUST be a Tdap (given in or after 2005)..

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
DTaP/DTP/Td (Diphtheria/Tetanus/Pertussis or Tetanus/Diphtheria Toxoid)	02/19/1999	04/23/1999	06/18/1999	06/23/2004
Tdap booster (All Students MUST show proof of a Tdap booster given in or after 2005)	03/25/2010			
Polio – 3 doses, only required if 17 years of age or younger	02/19/1999	04/23/1999	06/30/1999	06/23/1999
MMR (Measles, Mumps, Rubella) – 2 MMR vaccines required on or after first birthday OR 2 Measles, 2 Mumps and 1 Rubella single doses OR positive Measles, Mumps, Rubella titers.	12/13/1999	06/23/2004		
Measles – 2 required on or after first birthday OR positive titer OR documented disease date.			Disease Date	**Titer Date & Result (n/a)
Mumps – 2 required on or after first birthday OR positive titer			(Disease Date NOT Accepted)	**Titer Date & Result (n/a)
Rubella – 1 required on or after first birthday OR positive titer			(Disease Date NOT Accepted)	**Titer Date & Result (n/a)
Hepatitis B Series – only required if born after July 1, 1994	12/11/1998	01/13/1999	06/18/1999	Titer NOT Accepted for required Hep B Series

SECTION B RECOMMENDED IMMUNIZATIONS

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Has the student received the Meningococcal vaccine (Menatctra, Menveo, Menonune, MPSV4, MCV4)? ☐ N/A ☒ Yes ☐ No				
If **Yes**, date(s) received - **Booster dose recommended at age 16**	09/27/2011			
Meningococcal B vaccine (Bexsero or Trumenba - Please discuss risks and benefits of this vaccine with your medical provider)				
Hepatitis A	06/13/2014			
Hepatitis A/B combination series				
Pnuemococcal				
Human Papilloma Virus (HPV) – Cervarix	09/27/2011	12/06/2011	08/29/2012	
Human Papilloma Virus (HPV) – Gardasil X				
Human Papilloma Virus (HPV) – Gardasil-9				
Varicella (2 doses, documentation of disease date or positive titer)	12/12/1999	03/25/2010	Disease Date	**Titer Date & Result (n/a)
Tuberculin Skin Test (TST) Date Read				
mm induration	mm	mm	mm	mm
Date of IGRA (QuantiFERON or T-SPOT) test			**Chest X-ray Date:	
Result of IGRA test	Positive Negative N/A	Positive Negative N/A	**Chest X-ray Date:	Positive Negative N/A

** Must attach laboratory results

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

Office Address **City** **State** **Zip Code**

Student Name: Erin Goeke **DOB:** 12/08/1998 **PID #:** 730203991

Tuberculosis (TB) Screening Questionnaire Please complete and return to Campus Health Services along with the Immunization and Health History Form and signed Patient Agreement.

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ■ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? ☐ Yes ■ No
(If yes, please CIRCLE the country, below)

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cabo Verde
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia and Montenegro
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
South Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Yemen
Zambia
Zimbabwe

Have you had frequent or prolonged visits (this usually means a cumulative time of one month) to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above) ☐ Yes ■ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ■ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ Yes ■ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol? ☐ Yes ■ No

If the answer is YES to any of the above questions, CHS strongly recommends that you receive TB testing as soon as possible and forward that result to CHS or you can get a TB screening test at CHS once school starts.

If the answer to all of the above questions is NO, no further testing or further action is required, please submit this form to Campus Health Services along with the Health History & Immunization for and Patient Agreement.

CAMPUS HEALTH SERVICES PATIENT AGREEMENT

Permission for Diagnostic and Treatment Procedures: I authorize Campus Health Services (CHS), their employees and consultants, to perform diagnostic and treatment procedures that, in their judgment, may be medically necessary. I agree that I will be involved and engaged in my care and treatment. If I require specialized and/or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of CHS.

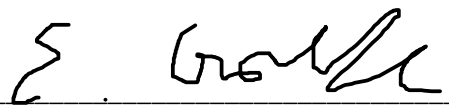
Confidentiality: Medical and mental health information contained CHS health record is strictly confidential and may only be released to outside sources with written permission from the patient, by a court order, or when permitted by law. Confidentiality and privacy is protected in all CHS business relationships to prevent the exchange of any patient specific information without permission. In the instance where an outside medical provider orders lab tests or allergy injections for patients at CHS, the results or follow-up from those tests or visits will be relayed back to the ordering provider. In addition, if a CHS provider refers you to an outside provider; your records pertaining to that referral may also be released.

Notification: I authorize CHS to contact me via University e-mail to include, but not limited to, appointment reminders, pre-matriculation immunization requirements, insurance claim inquiries, etc. I am aware that I may opt-out of receiving e-mail correspondence by calling CHS at (919) 966-2283. Because conventional email is inherently unsecured and the confidentiality of sensitive medical information cannot be assured, it is advised for matters that are sensitive in nature to contact CHS directly by calling 919-966-2281 or by sending a secure message through the patient portal at https://healthyheels.unc.edu.

Financial Information and Authorization to Process Insurance Claims: All UNC students are required to have health insurance either through an individual policy or through their family policy. CHS will file insurance claims on behalf of patients. The filing of claims does not guarantee either full or partial payment by the insurance company. For more information about using insurance at Campus Health Services (including which insurance companies are In-Network and Out-of-Network at CHS), please visit: http://campushealth.unc.edu/charges-insurance/using-insurance-campus-health. Please remember that the CHS Pharmacy is In-Network with virtually all US health insurance plans.

I, the undersigned, authorize the release of any protected health information to my insurance company and/or their agents that is necessary to process claims for services rendered by CHS or to obtain prior approval or authorizations for services or prescriptions. These agents may include, but are not limited to, any plan administrator, pharmacy benefits manager, underwriter, sponsor, or third party organization that contracts with my insurance company. I hereby authorize my insurance company to distribute the payment of my coverage directly to CHS. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize CHS to place any unpaid charges on my student account at the Office of Student Accounts and University Receivables (SAUR). I understand the office of SAUR may place a registration hold on my account for any unpaid CHS charges. I understand I cannot use Title IV federal financial aid to pay CHS charges unless I have signed permission with the Office of Scholarship and Student Aid. If I am a student at UNC-Chapel Hill, I understand that I am responsible for any charges incurred by my spouse or partner if treated at CHS. I authorize the use of this signature on all insurance submissions. I may elect to pay any bill in full in lieu of submitting a claim for insurance reimbursement.

I verify by my signature below that I have read and understood the above information and give my permission as stated above.

Signature of Patient:  Date: 06/15/2017

Printed Name of Patient: Erin Goeke PID#: 730203991

Signature of Parent/Guardian (If patient is under age 18:_____Date: _____