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Mandatory Medical Information

Student Health Services Requires 3 Steps for compliance with part of your University Requirements

Step 1: Immunizations

- **Include your FULL NAME and Date of Birth on all pages of your documents**
- **All immunization records are required to be submitted in, or translated into, English.**

Step 2: Completed Health Form (signed by health provider)

Step 3 Step 2: Insurance Waiver or Enrollment (can be completed once you register for classes) ***(can be completed once you register for classes)***

Email ALL immunizations and Health form to: shawuhealth@shawu.edu

***Immunizations and Physicals are not administered by the University Health Clinic**

***Places to get your Immunization Record:**

Previous high Schools and colleges

Previous doctors and clinics

Public health departments

North Carolina Immunization Registry (ask your NC provider to access)

Got a vaccine out of state? Find out if a state has a vaccine database like North Carolina: https://www.cdc.gov/iis/contacts-locate-records/index.html

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Need to get a Vaccine or Physical?

Wake County Health & Human Services (WCHHS) offers state required as well as recommended:

Public Health Center
10 Sunnybrook Road
Raleigh, NC 27610
Call 919-250-3900 to make an appointment.

Deadline Fall Semester, September 16, 2025

North Carolina Required Immunization Information

******Important Immunization Update******

Recently the North Carolina Immunization Branch informed all higher education institutions within the state that one dose of Meningococcal Conjugate Vaccine, given on or after a student's 16th birthday, is required for students enrolling for the Fall 2024 semester. Please see the updated requirements below.

REQUIREMENTS

North Carolina law requires individuals attending a college or university, whether public, private or religious, to receive certain immunizations. The registrar of the college or university is responsible for assuring the required immunizations have been received by all new (undergraduate and graduate) students enrolling in college at any time during the year.

The statute applies to all students **except** students residing off-campus and registering for any combination of:

- Off-campus courses
- Evening courses (classes beginning after 5 p.m.)
- Weekend courses
- No more than four-day credit hours on campus courses

Per North Carolina state law, students will be **WITHDRAWN FROM THE UNIVERSITY** 30 days after classes begin if immunization requirements have not been met.

For more information, please visit North Carolina State Law Immunization requirements.

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REQUIRED IMMUNIZATIONS

Vaccine	**Minimum Number of Doses Required**	
Diphtheria/Tetanus/Pertussis	3 doses (must include 1 Tdap)	
Polio	3 doses	
Measles	2 doses	2 doses of the MMR vaccine will meet this requirement
Mumps	2 doses	
Rubella	1 dose	
Hepatitis B	3 doses	
Varicella	1 dose	
Meningococcal Conjugate	1 dose	

- Diphtheria/Tetanus/Pertussis: Three (3) doses
    - Students entering college or university for the first time on or after July 1, 2008, must have had at least three doses of tetanus/diphtheria toxoid; one of which must be Tdap booster (tetanus, diphtheria, and pertussis).
    - The Tdap booster must have been given between 10 to 12 years of age or when entering the 7th grade.
- Polio: Three (3) doses
    - An individual attending school who has attained their 18th birthday is not required to receive polio vaccine.
- Measles: Two (2) doses (or 2 MMR doses)
    - Both doses must have been given on or after the first birthday.
    - Antibody testing confirming immunity to measles will be accepted In lieu of vaccine.
- Mumps: Two (2) doses (or 2 MMR doses)
    - Both doses must have been given on or after the first birthday.
    - Antibody testing confirming immunity to mumps will be accepted In lieu of vaccine.

  - Students that entered college or university before July 1, 2008, are not required to receive the second dose of mumps vaccine.
- Rubella: One (1) dose (or MMR dose)
  - Must have been given on or after the first birthday
  - Antibody testing confirming immunity to rubella will be accepted In lieu of vaccine.
- Hepatitis B: Three (3) doses
  - A two-dose series of Heplisav-B is acceptable (this vaccine is only available in the United States).
  - Antibody testing for Hepatitis B will **NOT** be accepted. Students must show documentation of a completed Hepatitis B vaccine series.
  - Hepatitis B vaccine is not required if a student was born before July 1, 1994.
- Varicella: One (1) dose
  - Documentation from a medical provider verifying varicella disease is accepted in lieu of vaccine dates.
  - Antibody testing confirming immunity to varicella will be accepted In lieu of vaccine.
  - Varicella vaccine or proof of immunity is not required if a student was born before April 1, 2001.
- Meningococcal Conjugate: One (1) dose *******New Requirement as of Fall 2024*******
  - Must have been given on or after the 16th birthday.
  - Vaccine brands that satisfy this requirement are: Menactra, Menveo, MenQuadfi, and Penbraya.
  - Meningococcal B vaccines (Bexsero & Trumenba) will **NOT** meet this requirement.
  - Meningococcal is not required if a student was born before January 1, 2003.

For further information, please stop by: (Located across the street from campus at the intersection of MLK and Person)

Student Health Service:

302 MLK BLVD, Raleigh, NC

Contact SHS at: 919.719.6324 (office) /shawuhealth@shawu.edu **(email)**

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SHAW UNIVERSITY STUDENT HEALTH SERVICE

SHAW University

118 East South Street
Raleigh, North Carolina 27601

Phone: 919-719-6324
shawuhealth@shawu.edu
www.shawu.edu/StudentHealthCenter

REPORT OF MEDICAL HISTORY:

(To be completed by student / parent, for review by physician)

Shaw ID # _____

Gender _____

_____ /_____ /_____

Last Name (print) First Name **Middle Initial** **Date of Birth** **Social Security Number**

_____

HOME ADDRESS (NUMBER & STREET **CITY** **STATE** **ZIP** **CELL #** **HOME #**

_____

☐Fr. ☐ Soph. ☐ Jr. ☐ Sr. ☐ Grad ☐Yes (Date: _____) ☐No ☐ Fall ☐ Winter ☐ Spring ☐ Summer 20_____

CLASS YOU ARE ENTERING (Check) **PREVIOUSLY ENROLLED HERE** **PROPOSED DATE OF REGISTRATION**

_____

HEALTH INSURANCE: NAME OF COMPANY **ADDRESS** **POLICY NUMBER**

_____

In case of Emergency Notify: **NAME** **RELATIONSHIP**

_____

Cell # **Home #** **Other #**

PARENTS OF STUDENTS UNDER 18: I hereby authorize any medical treatment for my son / daughter which may be advised or recommended by the physicians of Shaw University Student Health Services.

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FAMILY HISTORY	YES	NO	Relationship
Asthma, Hay Fever	☐	☐	
Autoimmune Disease	☐	☐	
Cancer (Specify)	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
Hypertension	☐	☐	
Psychiatric Disorder	☐	☐	
Seizure Disorder	☐	☐	
Stomach Disorder	☐	☐	
Sudden Death, cause unknown, before age 50	☐	☐	

_____ Signature of Parent / Guardian Date

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PERSONAL HISTORY: Please comment on all yes answers in the comment section or on an additional sheet.

HAVE YOU HAD / HAVE:	Y	N	COMMENTS / ADDITIONAL INFORMATION
Any disease or condition that is being followed by a physician for treatment, which should be continued or periodically evaluated? (Give details)	☐	☐	
Have any drug allergies or other known sensitivity or intolerance? (Give details and treatment.)	☐	☐	
Any illness, injury, operation or been hospitalized other than as already noted above? (Give details)	☐	☐	
Your physical activity has been restricted during the last five years? (Give reasons and duration.)	☐	☐	
Ever been hospitalized for mental or emotional illness? (Give name(s) phone number, and address of doctors and /or hospital addresses.	☐	☐	
Ever had to interrupt school or work either because of mental or emotional illness or after psychiatric consultation? Give details and doctors' names(s) phone number and addresses.	☐	☐	

STATEMENT BY STUDENT / PARENT: 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 the Shaw University Student Health Physician(s) any information you may have concerning my medical condition and your professional contact with me.

_____ _____

Signature of Student / Parent Date Physicians Signature (Acknowledging Review) Date

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PHYSICAL EXAMINATION

TO THE EXAMINING PHYSICAN: Please review the student's history, complete the physical examination form, and comment on all positive answers. The information supplied will be used only as a background for providing health care, if necessary. It is strictly for the use of the Student Health Service and will not be released without the student's consent. Please include any laboratory diagnostic exams that are medical history appropriate.

_____/_____/_____

Last Name **First Name** **Middle Initial** **Date of Birth** **Social Security Number**

Height_____ Weight_____ B.P._____/_____ Pulse_____/min

Contact Lenses: ☐ Y ☐ N	**Vision**:	**Hearing (gross)**	**LMP Date:**
Glasses: ☐ Y ☐ N	Corrected: R 20/ L 20/	Right: Pass Fail	Regular ☐ Y ☐ N
	Uncorrected: R 20/ L 20/	Left: Pass Fail	How many in a year?

Medication Allergies:

Food Allergies:

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Are there abnormalities of the following systems? Describe if yes, use additional sheet if necessary

	YES	NO	
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Hands / Feet			
Mammary			

Is there loss or seriously impaired function of any paired organ? Yes ☐ No ☐

If yes, explain:_____

Is there loss or seriously impaired function of any paired organ? Yes ☐ No ☐

If yes, explain:_____

Do you have any recommendations regarding the care of this student? Yes ☐ No ☐

If yes, explain:_____

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Do you have any recommendations regarding the care of this student? Yes ☐ No ☐

If yes, explain:_____

Do you have any recommendations regarding the care of this student? Yes ☐ No ☐

If yes, explain: _____

Is this student now under treatment for any medical or emotional condition? Yes ☐ No ☐

If yes, explain: _____

REQUIRED: Recommendations for physical activity for Phys. Ed., Intramurals, Intercollegiate, General education requirements.

☐ Unlimited ☐ Limited ☐ No PE.

Explain if limited or no PE:_____

Do you have any recommendations regarding the care of this student? Yes ☐ No ☐

If yes ,explain:_____

Do you have any recommendations regarding the care of this student? Yes ☐ No ☐

If yes, explain:_____

Is this student now under treatment for any medical or emotional condition? Yes ☐ No ☐

If yes, explain: _____

REQUIRED: Recommendations for physical activity for Phys. Ed., Intramurals, Intercollegiate, General education requirements.

☐ Unlimited ☐ Limited ☐ No PE.

Explain if limited or no PE:_____

Signature of Physician/ Physician Assistant/ Certified Nurse Practitioner_____

Date _____ OFFICE/CLINIC STAMP WITH ADDRESS AND TELEPHONE NUMBER

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Tuberculin Skin Test (within one year)

Date applied_____ Date read _____ by _____

Positive _____mm Negative_____

Chest x-ray if positive skin test Date _____ Attach results

NORTH CAROLINA STATE LAW REQUIRES ALL NEW AND TRANSFER ENROLLEES PROVIDE PROOF OF UPDATED IMMUNIZATIONS: Please attach immunization record from high school, doctor's office, or local Health Department.

If students plans to participate in intercollegiate sports, you must provide a sickle cell screen blood test. Please attach results of sickle cell lab test to physical form. Mail all medical information to: **Shaw University Student Health Services, 118 East South Street, Raleigh, North Carolina, 27601**

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North Carolina College Vaccination requirements Log

Student Information

Name: _____

Date of Birth: _____

Student ID: _____ (if known)

Vaccine Type	Date Administered	Administering Clinic	Provider Sign	Notes
DTaP Dose 1				
DTaP Dose 2				
DTaP Dose 3				
Polio Dose 1				
Polio Dose 2				
Polio Dose 3				
MMR Dose 1				
MMR Dose 2				
Rubella Dose				
Hep B Dose 1				
Hep B Dose 2				

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Hep B Dose 3				
Varicella Dose				
MenACWY Dose 1				
MenACWY Dose 2				