Immunization Form

Name: _____ Date of Birth: _____
Last First Middle/Maiden MM/DD/YYYY

UNC PID#: _____ Phone: ☐ Cell ☐ Home _____ Email: _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Self-Identify_____

Year Entering UNC: _____ Semester: ☐ Fall ☐ Spring Incoming Class: ☐ Undergraduate ☐ Graduate ☐ Professional

Previously enrolled at UNC Chapel Hill? ☐ No ☐ Yes International Student: ☐ No ☐ Yes - Country of Origin_____

Please have your local health care provider sign and date this form to verify all immunization dates **OR** you may attach copies of a verified certificate of immunization. All records must be uploaded through your To Do list item on your Connect Carolina Students Services Page by June 15th for fall admits and December 15th for spring admits. **Per North Carolina law, YOU WILL BE WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if immunization requirements have not been met.**

SECTION A – Required Immunizations for All Incoming Students					
Immunization Name		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
All students must submit documentation of 3 DTP/DTaP/Td/Tdap vaccines regardless of age. One of the three vaccines MUST be a Tdap booster.					
DTP/DTaP/Td - Diphtheria/Tetanus/Pertussis or Tetanus/Diphtheria Toxoid					
AND					
Tdap booster - All Students MUST show proof of a Tdap booster (Tetanus, Diphtheria and Pertussis)					
Hepatitis B (required if born after July 1, 1994)	3 dose vaccination series				Titer NOT Accepted
	OR				
	2 dose Heplisav-B vaccination series (available in the US only)			Titer NOT Accepted	
MMR - 2 MMR (Measles, Mumps and Rubella) vaccines given AFTER first birthday					
	Measles - 2 vaccines required given on or after first birthday OR positive titer OR documented disease date			Disease Date	**Titer Date & Result
OR	**Mumps** - 2 vaccines required given on or after first birthday OR positive titer			Disease Date NOT Accepted	**Titer Date & Result
	Rubella - 1 required vaccine given on or after first birthday OR positive titer			Disease Date NOT Accepted	**Titer Date & Result
Polio - 3 vaccines (required if 17 years of age or younger when classes begin)					
Varicella - 1 vaccine (2 doses preferred), Approximate Age/Date of Disease or positive titer (required if born after April 1, 2001)				Approx Age or Date of Disease	**Titer Date & Result

**** Must attach a copy of laboratory results for all titers**

Continue on reverse →

Immunization Form Continued

Student Name: _____ PID#:_____

SECTION B – Recommended Immunizations (not required)					
Immunization Name		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
COVID-19	Johnson & Johnson (Janssen) - 1 dose				
	Moderna - 2 dose series				
	Pfizer - 2 dose series				
	Other:				
Hepatitis A - 2 dose series					
Hepatitis A/B combination series					
Human Papillomavirus (HPV) Gardasil or Gardasil-9					
Meningococcal Quadrivalent (ACWY)					
Meningococcal B vaccine	Bexsero				
	Trumenba				
Pneumococcal	Prevnar 7				
	Prevar 13				
	Pneumovax				

Tuberculosis Screening: Students from countries with an increased incidence of Tuberculosis (TB) must provide documentation of TB screening which was performed within one year prior to matriculation. An IGRA Blood Test (acceptable from home country) or a TB skin test (must have been performed in the United States) is acceptable. Please see the following link for more information: https://campushealth.unc.edu/services/immunizations/international-student-tb-information

IGRA Blood Test (QuantiFERON or T-SPOT) **Must attach a copy of laboratory results**		Tuberculin Skin Test (TST) **Must have been performed in the United States in the last year**		
Date of Test	Result of Test ☐ Positive ☐ Negative	Date Placed	Date Read	Result _____ mm induration

_____ _____
Signature and Credentials of Health Care Provider Date

_____ _____
Printed Name and Credentials of Health Care Provider Office Phone Number

_____ _____
Office Address City State Zip Code

For more information, please email immunizations@unc.edu or visit https://campushealth.unc.edu/services/immunizations

CAMPUS HEALTH PATIENT AGREEMENT

Permission for Diagnostic and Treatment Procedures: I authorize Campus Health, their employees and consultants, to provide medical treatment and perform diagnostic procedures and services, which in their judgment may be medically necessary for my care. These may include the use of clinical photography as well as requesting and accessing information available from third party payors and other healthcare providers about my prescription medications, including my prescription medication history and medications that are covered by my insurance plan. 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 appropriate outside medical facilities or professionals. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of Campus Health.

Confidentiality: Medical and mental health information contained the Campus 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. Legally permitted disclosures may include reporting the purchase of pseudoephedrine or controlled substances and the disclosure of patient information to State and federal agencies with jurisdiction over health care disciplines when required by an on-going investigation. Confidentiality and privacy is protected in all Campus Health 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 Campus Health, the results or follow-up from those tests or visits will be relayed back to the ordering provider. In addition, if a Campus Health provider refers you to an outside provider or needs to obtain a prior authorization for a medication, treatment, or procedure, your records pertaining to that referral or prior authorization may also be released.

Notification: I authorize Campus Health to contact me via University e-mail to include, but not limited to, appointment reminders, immunization requirements, insurance claim inquiries, etc. I am aware that I may opt-out of receiving e-mail correspondence by calling (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 Campus Health directly by calling (919) 966-2281 or by sending a secure message through the patient portal at https://healthyheels.unc.edu. To Opt Out of appointment reminder text messages from Campus Health, please call (919) 966-2283.

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. Campus Health 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, please visit: https://campushealth.unc.edu/charges-insurance/insurance.

I, the undersigned, have read and understood the above information and authorize the release of any medical or insurance information to my insurance company and/or their agents, including but not limited to any plan administrator, pharmacy benefits manager, underwriter, or sponsor, which is necessary to process claims for services rendered by Campus Health. The purpose of any release of my information is to administrate the provision of health services. I hereby authorize my insurance company to distribute the payment of my coverage directly to Campus Health. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize Campus Health 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 Campus Health charges. I understand I cannot use Title IV federal financial aid to pay Campus Health 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 Campus Health. 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 signing below I have read and understood the above information and give my permission as stated above.

Signature of Patient:_____ Date: _____

Printed Name of Patient:_____ PID#: _____

Signature of Parent/Guardian (If patient is under age18:_____ Date: _____