UNC Chapel Hill Immunization Form

Name: _____ Date of Birth:_____ PID#: _____
(Last, First, Middle/Maiden) (MM/DD/YYYY)

Preferred Name: _____Phone:_____ Email: _____

Sex at Birth: ○ Male ○ Female ○ Intersex/Ambiguous Pronouns: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Year & Semester Entering UNC: _____ ○ Fall ○ Spring ○ Summer Previously enrolled at UNC? ○ No ○ Yes

International Student? ○ No ○ Yes – Country of Origin: _____

Have your medical provider sign and date this form to verify all immunization dates entered **OR** you may attach a verified certificate of immunization with all required immunizations in lieu of a health care provider signature. All records must be uploaded through your To Do list item on your Connect Carolina Students Services Page. The general deadline is June 15th for fall admissions and December 15th for spring admissions.

Per North Carolina law, YOU WILL BE WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if immunization requirements have not been met.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 for ALL Incoming Students – provide all dates in MM/DD/YYYY format

MMR (Measles, Mumps, Rubella)

Two (2) doses required AFTER 1st birthday if born after 1956

First dose: _____

Second dose: _____

OR

Serologic test date: _____

Result:_____
(Must attach copy of results)

OR

○ Born before 1956

Diphtheria, Tetanus and Pertussis

At least three (3) doses are required for individuals entering college or university after July 1, 2008, one of which can be a Tdap booster.

First dose: _____

Second dose: _____

Third dose: _____

Tdap booster

***ALL** Students **MUST** show proof of a Tdap (Tetanus, Diphtheria and Pertussis) that was given when entering the 7th grade or later.*

Date given:_____

Varicella (Chickenpox)

Required if born after April 1, 2001
1 dose (2 doses preferred), approximate age/date of disease or positive serologic test.

First dose: _____

Second dose: _____

OR

Age/date of disease: _____

OR

Serologic test date: _____

Result: _____
(Must attach copy of results)

Hepatitis B Vaccine

(Required if born after July 1, 1994) *Either the 3 dose series OR 2 dose HEPLISAV-B series accepted. ***Serologic test NOT accepted** – must show proof of vaccine dates.*

Three dose series

First dose: _____

Second dose: _____

Third dose: _____

OR

Two dose series (HEPLISAV-B)
(only valid after November 2017)

First dose: _____

Second dose: _____

Polio

Three (3) doses required ONLY if 17 years of age or younger when classes begin.

First dose: _____

Second dose: _____

Third dose: _____

(Continue on Reverse)

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SECTION B – Tuberculosis Screening – provide all dates in MM/DD/YYYY format

Tuberculosis Screening REQUIRED for students from countries with an increased incidence of Tuberculosis (TB)
See https://campushealth.unc.edu/services/immunizations/international-student-tb-information for list of countries and more information.

Required to provide documentation of TB screening which was performed within one year prior to matriculation. Acceptable tests include either an IGRA Blood Test (usually acceptable from home country; report must contain student demographic information and results must be in English) or a TB skin test performed in the United States.

Campus Health may recommend additional TB screening or work up after review of records submitted.

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

SECTION C – Recommended Immunizations (NOT REQUIRED) – provide all dates in MM/DD/YYYY format

Meningococcal Vaccine
Quadrivalent vaccine (A, C, Y, W-135) or Pentavalent (ABCWY) *Two (2) doses OR one (1) dose, if first dose was given on or after age 16)*

Vaccine name: _____

First dose: _____ Second dose:_____

Pneumococcal Vaccine
(e.g., PCV13, PCV15,PCV20, PPSV23)

Vaccine name: _____

First dose: _____ Second dose:_____

Human Papillomavirus (HPV)

First dose: _____

Second dose:_____

Third dose: _____

Hepatitis A

First dose: _____

Second dose: _____

Hepatitis A/B Combo Series

First dose: _____

Second dose: _____

Third dose: _____

_____ _____
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

Questions? 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 and general 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: _____