SUMMER INTENSIVES
HEALTH FORM ONLY

UNIVERSITY OF NORTH CAROLINA
SCHOOL OF THE ARTS

Welcome to UNCSA Summer Intensives! We look forward to serving your primary health care needs. A complete list of Health Services we offer and forms are located on: uncsa.edu/current-students/health-wellness/health-center/index.aspx

Use the checklist below to ensure you have completed these forms in their entirety. UNCSA policy requires completion of these forms. Students without completed forms will not be able t o participate in summer intensives.

Be sure to have your name on EVERY page
A non-relative medical provider MUST complete & sign the Physical Exam form found in this packet
*****KEEP A COPY OF THESE COMPLETED FORMS FOR YOU RECORDS*****

SUBMIT TO: UNC School of the Arts
Health Services
1533 S Main Street
Winston-Salem, NC 27127

DEADLINE: April 25, 2025

Health forms can only be submitted via mail.

PHYSICAL EXAMINATION

☐ All students must have a physical exam prior to attending UNCSA Summer Intensives completed on the form provided.
☐ The physical examination must be within 12 months of UNCSA Summer Intensive registration day which is June 23, 2025.
☐ Documentation of a Tdap (Tetanus, Diphtheria, Pertussis) which must have occurred within the past 10 years is required.
☐ The physical examination must be fully completed, as per the instructions at the top of the physical examination, regardless of the summer intensive being attended.

HEALTH HISTORY FORM

☐ If you are under 18 years of age the "statement by student/parent/guardian" must be signed by both parent/guardian and student.
☐ Include two daytime phone numbers that we may use to reach contacts in an emergency.

INSURANCE

☐ All students are required to have a major medical insurance policy.

SHARING COMPLETE MEDICAL HISTORY

☐ All students are requested to share their complete medical history via medical records to provide optimal medical care.

COVID-19 VACCINATION

☐ All students have the OPTION to include their COVID-19 vaccination record with the required forms.

FINAL STEPS

☐ Make a copy of all completed forms for your records.
☐ Submit completed forms to UNCSA Health Services - Deadline is April 25, 2025

For questions contact Health Services at 336-770-3288

Forms for 2025 Summer Intensive
These are the only forms acceptable

Updated 10/2024

Summer Intensives Health Form Only

REPORT OF MEDICAL HEALTH HISTORY *(Please print in black ink)*

LAST NAME (print) | FIRST NAME | MIDDLE/MAIDEN NAME | Date of Birth (mo/day/year)

PERMANENT ADDRESS | CITY | STATE | ZIP CODE | EMAIL ADDRESS | STUDENT CELL PHONE NUMBER

Summer Intensive Program Attending:_____ High School ☐ College ☐

All students are required to have a major insurance policy.

Students must submit copies of the front and back of their health insurance and prescription card.

EMERGENCY Contact Name (Parent/Guardian) (RELATIONSHIP) Phone numbers to contact in emergency

EMERGENCY Contact Name (Other than Parent/Guardian) (RELATIONSHIP) Phone numbers to contact in emergency

FAMILY & PERSONAL HEALTH HISTORY *(Please print in black ink)* *To be completed by student*

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. ***Please attach additional sheets for any items that require fuller explanation.***

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

	Yes	No	Relationship
High blood pressure			
Blood or clotting disorder			
Heart attack before age 55			

	Yes	No	Relationship
Stroke			
Diabetes			
Cancer (type):			

	Yes	No	Relationship
Alcohol/drug problems			
Psychiatric illness			
Suicide			

Have you ever had or have now the following? (If yes, indicate the year.)

	Yes	No	Year
High blood pressure			
Cardiac disorder			
Asthma			
Pneumonia			
Chronic cough			
Tumor or cancer			
Malaria			
Thyroid disease			
Diabetes			
Serious skin disease			
Mononucleosis			
Organ transplant			
Celiac disease			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion			
Migraine headache			
Dizziness or fainting spells			
Paralysis			
Depression			
Excessive worry or anxiety or obsession			
Ulcer (duodenal or stomach)			
Bowel disease			
Treatment for ADD or ADHD			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Hernia			
Anemia or Sickle Cell Anemia			
Eye disease			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Autism/Aspergers			
Kidney disease			
Urinary infection			

	Y	N	Year
Seizure disorder			
Gall bladder disease or gallstones			
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Sexually transmitted infection			
Blood transfusion			
Alcohol use			
Illegal Drug use			
Eating disorder			
Tobacco Use			
Regularly exercise			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them. If you do not take anything put N/A.

Name_____ Use_____ Dosage_____ Name_____ Use_____ Dosage _____

Name_____ Use_____ Dosage_____ Name_____ Use_____ Dosage _____

Name_____ Use_____ Dosage_____ Name_____ Use_____ Dosage _____

Name_____ Use_____ Dosage_____ Name_____ Use_____ Dosage _____

Summer Intensive Health Form Only Name _____

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED (Please print in black ink) To be completed by student

	Yes	No		Yes	No
1. Has a doctor ever denied or restricted your participation in performances for any reason?			21. Has a doctor ever told you that you have asthma or allergies?		
2. Do you have an ongoing medical condition, such as diabetes or asthma?			22. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
3. Are you currently taking any prescription or non-prescription (over-the-counter) medications?			23. Is there anyone in your family who has asthma?		
4. Have you ever passed out or nearly passed out AFTER exercise?			24. Have you ever used an inhaler or taken asthma medicine?		
5. Have you ever had discomfort, pain, or pressure in your chest during exercise?			25. Have you had infectious mononucleosis (mono) within the last month?		
6. Does your heart race or skip beats during exercise?			26. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?		
7. Has a doctor ever told you that you have: (Check all that apply.)			27. Have you ever been hit in the head and been confused or lost your memory?		
High Blood Pressure?			28. Have you ever had a seizure?		
A Heart Murmur?			29. Do you have headaches with exercise?		
High Cholesterol?			30. Have you ever been unable to move your arms or legs after being hit or falling?		
A Heart Infection?			31. When exercising in the heat do you have severe muscle cramps or become ill?		
8. Has a doctor ever ordered a test for your heart? (For Example: ECG, echocardiogram)			32. Has a doctor you that you or someone in your family has sickle cell trait or sickle cell disease?		
9. Has anyone in your family died for no apparent reason?			33. Are you happy with your weight?		
10. Does anyone in your family have a heart problem?			34. Are you trying to gain or lose weight?		
11. Has any family member or relative died of heart problems or sudden death before age 50?			35. Has anyone recommended you change your weight or eating habits?		
12. Does anyone in your family have Marfan syndrome?			36. Do you limit or carefully control what you eat?		
13. Have you ever spent the night in a hospital?			37. Do you have any concerns that you would like to discuss with a doctor?		
14. Have you ever had surgery?			**Menstruating Individuals Only:**		
15. Have you ever had a stress fracture?			38. Have you ever had your menstrual period?		
16. Do you regularly use a brace or assistive device?			39. How old were you when you had your first menstrual period?		
17.Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?			40. How many periods have you had in the last 12 months?		
18 Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or performance? If yes; click area affected below:			**Explain "Yes" answers here:** _____		
19. Have you had any broken or fractured bones, or dislocated joints? If yes, click below:					
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, click below:					

Head ○	Neck ○	Shoulder ○	Upper Arm ○	Elbow ○	Forearm ○	Hand/ Fingers ○	Chest ○
Upper Back ○	Lower Back ○	Hip ○	Thigh ○	Knee ○	Calf/ Shin ○	Ankle ○	Foot/ Toes ○

North Carolina House Bill 808 prohibits a medical professional in North Carolina from providing, prescribing, or dispensing puberty blocking drugs or cross sex hormones to minors. UNCSA Student Health Services is unable to prescribe, continue, or store puberty blocking drugs, i.e., testosterone, for minor students under 18 years of age.

Summer Intensive Health Form Only Name _____

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED *(Please print in black ink) To be completed by student*

Check each item "Yes" or "No". Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin, ibuprofen, or Tylenol			
Codeine or pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical or mental activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past year? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my/my child's medical record to a physician, hospital, or other medical professional involved in providing me/my child with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself/my child that may be advised or recommended by the medical providers of Student Health Services.

(C) I am aware that the Student Health Services charges for some services and I may be billed if the account is not paid at the time of visit. I accept personal responsibility for settling the account and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage.

(D) Student Health Services has a close working relationship with Atrium Health Wake Forest Baptist Medical Center. If you are referred to the Atrium Health Wake Forest Baptist Medical Center, we may provide them with a copy of the appropriate medical records so they may provide you with the best care possible. In turn, we may utilize the last 4 digits of your social security number to access your records from Atrium Health Wake Forest Baptist Medical Center to provide appropriate follow-up and care on your return to campus.

_____ _____ _____

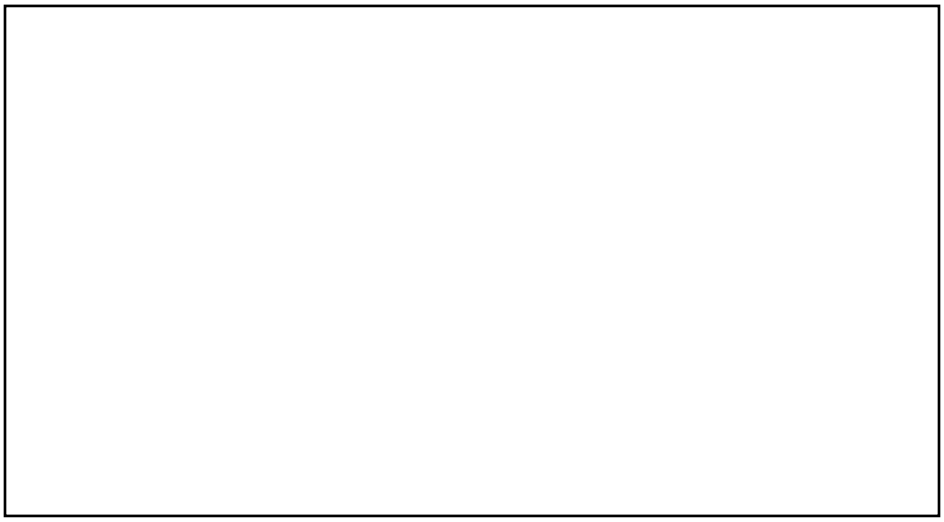
Signature of Student **Date** **Last 4 digits of Social Security number**

_____ _____

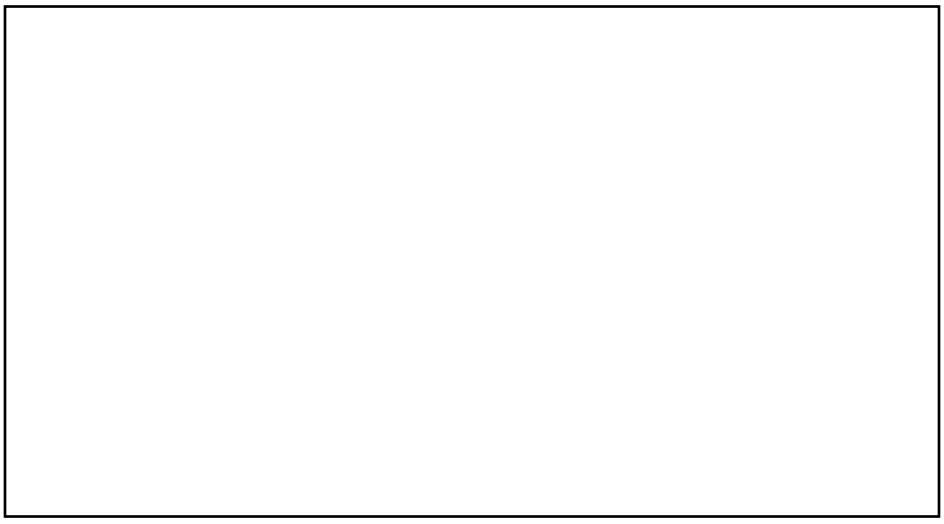
Signature of Parent/Guardian, if student under age 18 **Date**

 Name _____

Front of Insurance Card

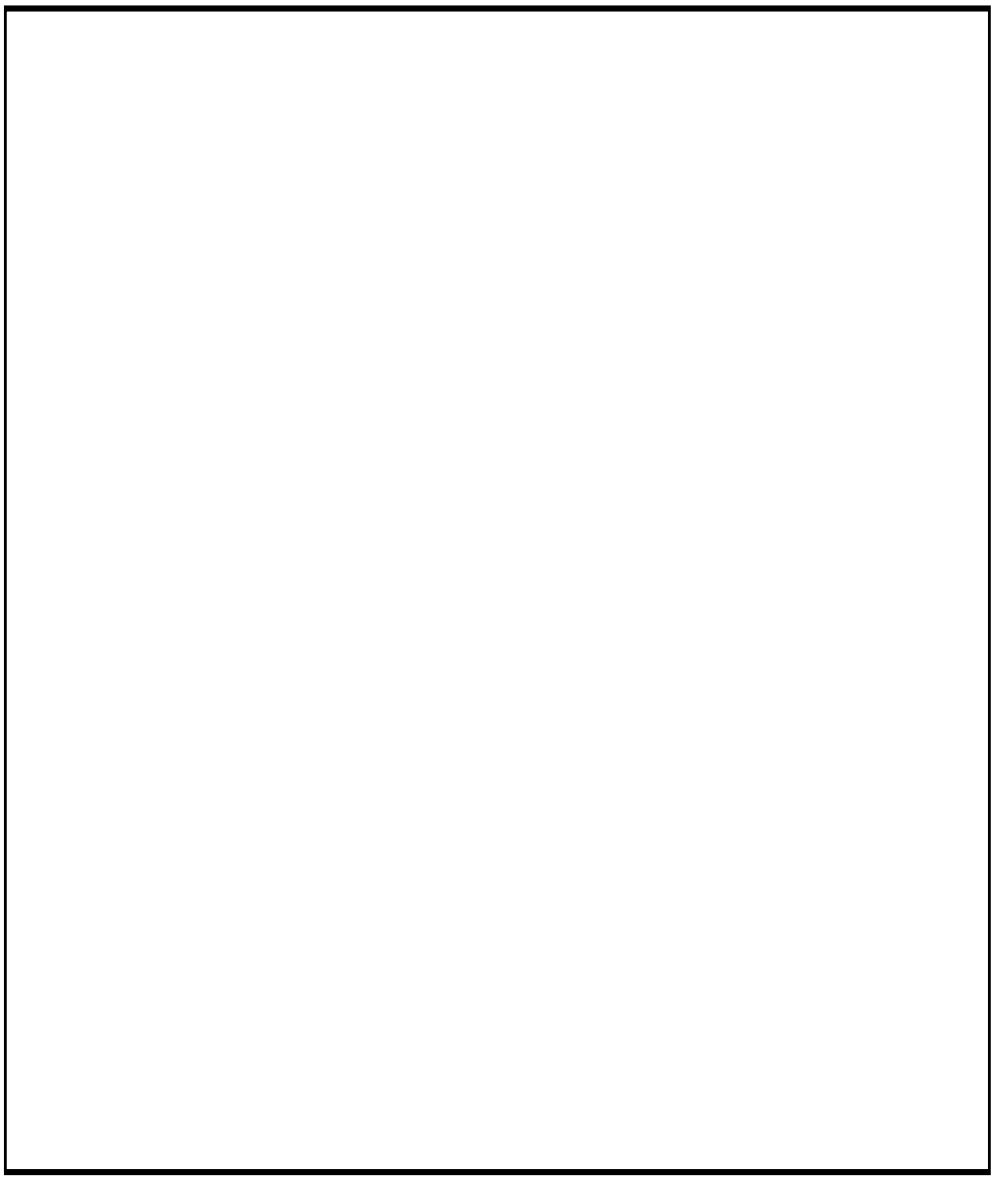


Back of Insurance Card



Summer Intensives Health Form Only Name _____

COVID-19 VACCINATION CARD



Summer Intensive Health Form Only

Name _____

Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

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 TYPE in the country: [ ])

Have you had frequent or prolonged visits* to one or more of the countries listed below with a high prevalence of TB disease?(If yes, please TYPE in the country: [ ]) ○ 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

- Angola
- Azerbaijan
- Bangladesh
- Belarus
- Botswana
- Brazil
- Cameroon
- Central African Republi
- China
- Congo
- Democratic People's Republic of Korea (North Korea)
- Democratic Republic of the Congo
- Eswatini
- Ethiopia
- Gabon
- Guinea
- Guinea-Bissau
- India
- Indonesia
- Kazakhstan
- Kenya
- Kyrgyzstan
- Lesotho
- Liberia
- Malawi
- Mongolia
- Mozambique
- Myanmar
- Namibia
- Nepal
- Nigeria
- Pakistan
- Papua New Guinea
- Peru
- Philippines
- Republic of Moldova
- Russian Federation
- Sierra Leone
- Somalia
- South Africa
- Tajikistan
- Thailand
- Uganda
- Ukraine
- United Republic of Tanzania
- Uzbekistan
- Viet Nam
- Zambia
- Zimbabwe

Source: WHO global lists of high burden countries for tuberculosis (TB), TB/HIB and multidrug/rifampicin-resistant TB (MDR/RR-TB), 2021-2025 https://cdn.who.int/media/docs/default-source/hq-tuberculosis/who_globalhbcliststb_2021-2025_backgrounddocument.pdf?sfvrsn=f6b854c2_9pdf

If the answer is YES to any of the above questions, UNC School of the Arts requires that you receive TB testing as soon as possible but at least prior to the start of your summer intensive program.

Acceptable TB screening tests include:

- Tuberculin Skin Test (TST) or,
- TB blood test (QFT-G or T-spot).

The TST or TB blood test must have been done within the 12 months prior to the start of the summer intensive pogrmas . Documentation of the TST is acceptable only from a United States facility.

Many people born outside of the United States have been given a vaccine called BCG. TB blood tests are the preferred method of TB testing for people who have received the BCG vaccine.

If the answer to all of the above questions is NO, no further testing or further action is required.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Summer Intensives Health Form Only

PHYSICAL EXAMINATION- *Must be **FULLY COMPLETED** and **SIGNED** by non-relative medical provider (MD, PA and/or NP) **for ALL SUMMER INTENSIVE attendees**.* **The physical MUST be completed on this form.**

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)

Permanent Address	City	State	Zip Code	Area Code/Phone Number

Height _____ Weight _____ BMI_____ TPR_____/_____/_____BP_____/_____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Eyes,Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Genitourinary			
7. Musculoskeletal			
8. Metabolic/Endocrine			
9. Neuropsychiatric			
10. Skin			

A. Is there loss or seriously impaired function of any organs? Yes _____ No

Explain _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____

Explain _____

C. Is student physically and emotionally healthy? Yes _____ No _____

Explain _____

D. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____

Explain _____

All programs are physically demanding. Specifically, our dance program is physically intensive program with students expected to dance an average of 5-6 hours a day.

E. Can the student actively participate in **ALL CLASSES** without restriction? Yes _____ No _____

If NO, what is the student actively not cleared for (ex: no lifting, no pointe work, no jumping, dance only to pain tolerance)?

_____

Reason: _____

Recommendations: _____

F. Is the student up to date & current on all required immunizations? Yes _____ No _____

G. Date of last Tdap (Tetanus, Diphtheria, Pertussis) which must have occurred within the past 10 years: _____ Month, Day, Year

H. Medications prescribed to student & dosages: _____

_____

Physician comments, recommendations, and review of history: _____

_____

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**

UNCSA High School Medication Policy

It is the policy of the University of North Carolina School of the Arts that high school students check their prescription medications, in the original prescription bottle, in with Health Services. Health Services will determine if the student may keep the medication in their room, or if it will be retained by Health Services and dispensed. The purpose of this policy is to:

- Assist the student with compliance and reordering medications
- Prevent and control loss and theft of medications
- Prevent abuse of medications
- Document medication compliance

The medications that must be checked in with Health Services are:

- Medications used to treat depression, anxiety, mood or bipolar disorders
- Medications used to treat Attention Deficit Disorder
- Seizure medications
- Controlled medications containing hydrocodone or other powerful pain relievers

It is required that high school students who live on campus have the necessary maturity and organizational skills to take their own medication on a daily basis.

Policy for Dispensing High School Medications:

Students present to Health Services for pickup of a 7-day pallet of medication on a weekly basis**. Students can pick up their weekly pallet of medication from Health Services on Monday or Tuesdays between 8:00 am-4:30 pm.**

Students and parents are responsible for reordering medications and having them delivered to Health Services. If Health Services is closed the medications are to be placed in the lock box located in the Campus Police Lobby. Students will be notified when they are running low on medications. **Summer Intensive students should only bring the number of pills needed for the duration of Summer Intensives.**

A new pallet of medication will not be dispensed to high school students presenting to Health Services less than 5 days from the previous medication pick-up, without consent and telephone authorization from a parent. Telephone authorization from a parent is also required for students presenting to Health Services for replacement of lost medication if less than 5 days from the previous medication pick-up.

Health Services is not responsible for a student's medication once a student has received their medication and leaves Health Services. If a high school student has missed their weekly pallet pick-up, the student's parent and/or guardian, and Director of High School Life/Director of Summer Intensives, will be notified. Please make sure we have correct phone and email contact information for this purpose.

*At the end of each semester/Summer Intensive/school break when students leave campus, additional and/or remaining medication will be released to high school students unless Health Services is notified by a parent not to release additional and/or remaining medication. **Please note that Health Services is prohibited by law from mailing drugs through the U.S. Postal Service.**

The remaining medication that is not picked up 2 weeks post commencement or 2 weeks post end of Summer Intensives will be disposed of.

Print Student Name: _____

Student Email: _____ Student Cell Number: _____

Student Signature: _____ Date: _____

Print Parent Name: _____

Parent Email: _____ Parent Cell Number: _____

Parent Signature: _____ Date: _____