

FALL 2010



Dear Student:

We are delighted you have decided to join us as a Coastal Carolina University student beginning in Fall 2010. In order to continue the enrollment process, we need additional information from you that is included in this packet. It is our goal to make this process as easy and convenient as possible. If you have any questions, there are several ways you can contact us for assistance:

Admissions Office

Telephone: 843-349-2026 or 843-349-2170 or 800-277-7000

E-mail: admissions@coastal.edu

Residence Life

Telephone: 843-349-6400

E-mail: reslife@coastal.edu

Student Health Services

Telephone: 843-349-6543

Thanks again for making the Coastal Carolina University choice. See you in August 2010!

Enrollment process:

1. Read the entire Enrollment Handbook.
2. Complete and return the Enrollment Notification Card along with a \$100 check or credit card authorization by May 1, 2010.
3. Complete and return the Health History/Immunization Form prior to August 1, 2010.
4. Complete the Residence Life Application/Contract and pay the \$150 housing deposit online at www.coastal.edu/reslife. Applications are accepted on a first-come, first-served basis for residence hall students only.

Office of Admissions

Coastal Carolina University

P.O. Box 261954 • Conway, SC 29528-6054 • www.coastal.edu

Immunization Form (Complete if you were born in 1957 or later.)

Last name _____ First name _____

Social Security number _____ Date of birth _____

Permanent address - PO Box, RFD, Street _____

City _____ State _____ Zip code _____

To achieve immunization compliance, students born in 1957 or later must provide Student Health Services with proof of 2 MMRs (Measles, Mumps and Rubella) **OR** 2 Measles (Rubeola), 1 Rubella and 2 Mumps **OR** documentation of physician-diagnosed measles, mumps and laboratory evidence of immunity to rubella. In addition, international students from high risk countries must provide a tuberculin skin test PPD (Mantoux) within the past six months. If there is a history of a positive skin test, a chest X-ray is required. All immunization and tuberculin skin test documents must be submitted in English. You must forward the required information to:

Student Health Services, Coastal Carolina University, P.O. Box 261954, Conway, SC 29528-6054
Telephone number: 843-349-6543 • Fax number: 843-349-6546

Required Immunizations

Measles/Mumps/Rubella (MMR) Dose #1: (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$ Dose #1: (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$
(2 doses required at least 28 days apart)

OR

Rubeola (Measles) (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$ Reimmunized (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$ **OR** Titer (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$ **OR** Illness (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$

Rubella (German Measles) (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$ Reimmunized (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$

Mumps (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$ Reimmunized (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$ **OR** Titer (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$ **OR** Illness (Date) $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$

Required Tuberculosis Screening (if from high risk countries)*

Tuberculin Skin Test (PPD)

(within past 6 months)

Date given: $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$ Date read: $\frac{\quad}{M} / \frac{\quad}{D} / \frac{\quad}{Y}$

Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive _____ negative _____

*Go to http://www.coastal.edu/health/i_requirements.html for list of high risk countries.

Coastal Carolina University • Student Health Services • Health History Form

Last name (print) _____ First _____ Middle _____
 Today's date _____ Social Security number _____
 Permanent address _____
 City _____ State/Country _____ Zip code _____
 Telephone number (_____) _____ Date of birth _____ Male Female
 Emergency contact: Name _____ Relationship _____
 Address _____
 Emergency contact telephone (_____) _____ Business telephone (_____) _____
 Marital status _____ Month/year you are entering the University _____
 Health insurance company name _____ Telephone (_____) _____
 Policy holder's name _____ Policy number _____

Are you ALLERGIC to any of the following?

Yes No MEDICATIONS: If yes, name _____
 Yes No FOOD: If yes, name _____
 Yes No INSECT VENOM: If yes, name _____
 Yes No POLLEN, DUST, MOLD, ANIMALS: If yes, name _____
 Yes No OTHER _____

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death		Yes	No	Relationship
Father	_____	_____	_____	_____	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	_____	_____	_____	_____	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brothers	_____	_____	_____	_____	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sisters	_____	_____	_____	_____	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	Depression/Drug/Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____

HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Rupture, Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Weight Changes	<input type="checkbox"/>	<input type="checkbox"/>	STDs	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	OTHER	_____	_____
MALES ONLY			FEMALES ONLY			Hernia Repair		<input type="checkbox"/>	_____		
Testicular Mass	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problem	<input type="checkbox"/>	<input type="checkbox"/>	Other surgery (specify):		_____			
Prostate Infection	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	_____		_____			

PRESENT MEDICATIONS: (Please include birth control, vitamins and herbal supplements.)

Drug	Dose	Reason
_____	_____	_____
_____	_____	_____

Do you smoke? No Yes If yes, how much _____
 Do you use alcohol? No Yes If yes, how much _____
 Do you exercise? No Yes If yes, how often/type _____

The above information is true to the best of my ability. I consent to medical treatment at Coastal Carolina University's Student Health Services. Payment for any incurred charges will be the responsibility of the student.

Student signature _____ Date _____
 (Parent signature required if student is younger than 16 years old.)



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