

# Enrollment Notification



Dear Student:

We are delighted that you have decided to join us as a Coastal Carolina University student. 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 1-800-277-7000  
E-mail: [admissions@coastal.edu](mailto:admissions@coastal.edu)
- ▶ **Residence Life**  
Telephone: 843-349-6400  
E-mail: [reslife@coastal.edu](mailto:reslife@coastal.edu)
- ▶ **Student Health Services**  
Telephone: 843-349-6543

Thanks again for making the Coastal Carolina University choice!

---

## 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 and the Health History/Immunization Form by the appropriate deadline below.

**Enrollment Deposit Deadlines:**

- December 15 for Spring enrollment
- April 1 for Maymester
- May 1 for Summer I
- June 1 for Summer II

3. Complete the Residence Life Application/Contract and pay the \$150 housing deposit online at [www.coastal.edu/reslife](http://www.coastal.edu/reslife). Applications are accepted on a first-come, first-served basis for residence hall students only. Please note that all new freshmen and transfers must pay the \$100 enrollment deposit before completing the housing contract. Once the enrollment deposit is received in the Office of Admissions, it will take 24 hours to generate the password needed to access the housing contract.

## Office of Admissions

Coastal Carolina University

P.O. Box 261954 • Conway, SC 29528-6054 • [www.coastal.edu](http://www.coastal.edu)



# Immunization Form *Complete if you were born in 1958 or after.*

\_\_\_\_\_

Last name (print)	First	Middle	Date of birth
-------------------	-------	--------	---------------

On the recommendation of the American Health Association and the South Carolina Department of Health, the following immunizations are required for all students including undergraduate, graduate, transfer and part-time students. Coastal Carolina University mandates that students be immune to measles and German measles. You must forward the required information to Student Health Services, Coastal Carolina University, P.O. Box 261954, Conway, SC 29528-6054; the telephone number is 843-349-6543.

Last name \_\_\_\_\_ Social Security number \_\_\_\_\_

First name \_\_\_\_\_ Date of birth \_\_\_\_\_

Permanent address - P.O. Box, RFD, Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

---

## Mandatory Immunizations

Rubeola (Measles) (Date) \_\_\_\_\_ Illness (Date) \_\_\_\_\_ Reimmunized (Date) \_\_\_\_\_

Rubella (German Measles) \_\_\_\_\_ Titer (Date) \_\_\_\_\_ Reimmunized (Date) \_\_\_\_\_

Measles/Mumps/Rubella (MMR) Dose 1 (Date) \_\_\_\_\_ Dose 2 (Date) \_\_\_\_\_

*Either certified immunization or positive titer is required. Previous clinical diagnosis of rubella is not sufficient.*

Physician's Signature or Stamp \_\_\_\_\_ Date \_\_\_\_\_

### ► Coastal Carolina University *recommends* the following additional immunizations:

• Tetanus Booster (Td) (Vaccination within last 10 years) Date \_\_\_\_\_

• Tuberculin Skin Test (PPD) (Within 6 months prior to beginning of class) Date \_\_\_\_\_

• Hepatitis B (3 doses) Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

• Varicella (Immunization or Disease) Date \_\_\_\_\_

• Meningitis Vaccine (*Strongly recommended by the American College Health Association*) Date \_\_\_\_\_

Physician's Signature or Stamp \_\_\_\_\_ Date \_\_\_\_\_

# Coastal Carolina University • Student Health Services • Health History Form

Last name (print) \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 Today's date \_\_\_\_\_ Social Security number \_\_\_\_\_  
 Home address \_\_\_\_\_  
 City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip code \_\_\_\_\_  
 Telephone number ( \_\_\_\_\_ ) \_\_\_\_\_ Date of birth \_\_\_\_\_  Male  Female  
 Emergency contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 Emergency contact telephone ( \_\_\_\_\_ ) \_\_\_\_\_ Business telephone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Health insurance (include copy) \_\_\_\_\_ Marital status \_\_\_\_\_  
 Month/year you are entering Coastal Carolina University \_\_\_\_\_

**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
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**FAMILY HISTORY**

	Yes	No	Relationship
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
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"/>	Eating Disorders	<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"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Ear problems	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<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"/>	Rupture, Hernia	<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"/>	Scarlet Fever	<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"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	OTHER	_____	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<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"/>	_____	_____	_____
MALES ONLY			FEMALES ONLY			Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Testicular Mass	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problem	<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Prostate Infection	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<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.

Student signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent or legal guardian's signature required if student is younger than 18 years of age.)