

VERMONT TECH

Mandatory Health Form

*ALL HEALTH PROFESSIONS STUDENTS: NURSING, DENTAL, RADIOLOGIC
SCIENCE, RESPIRATORY THERAPY AND PARAMEDICINE*

COMPLETE AND SEND TO:
Vermont Tech Health Center and Upload to CastleBranch

PRIOR TO: June 1

TO: New Vermont Technical College Students
RE: Health Form & Immunization Record

Congratulations on your acceptance to Vermont Technical College! We welcome you to our community.

THE ENCLOSED FORM REQUIRES YOUR IMMEDIATE ATTENTION. ATTENDANCE CANNOT BE PERMITTED UNTIL A COMPLETED HEALTH FORM IS RECEIVED.

Be sure to complete all pages. **The third and fourth pages are to be completed by your health care provider.** Most of the specific questions asked are to fulfill our responsibility to protect the health of the college community. **Please submit all four (4) pages to Castle Branch as well as the Vermont Tech Health Center. Make a copy for your records before submitting a hard copy to Vermont Technical College, Health Center, and PO Box 500, Randolph Center, VT 05061.**

Due to problems with immunity in many college-age persons, and the close living conditions in the residence halls, outbreaks of measles and other vaccine preventable diseases have become increasingly frequent on college campuses. Serious complications can occur from these diseases, especially measles. If you have difficulty with immunization data, the school that you most recently attended may have this information.

Hepatitis B vaccine is now a Vermont required immunization. Community living on a college campus supports an environment where sharing of illness occurs, including communicable diseases such as Hepatitis B. You may also want to consider vaccination against meningococcal disease. First year students living in residence halls are at a greater risk. Please discuss this with your health care provider when you have your physical.

Health Professions students are not exempted from immunization requirements. Immunization documentation is a requirement of all clinical facilities that host these students. Please contact your site or program director with any questions or concerns.

◆ **NOTE:** Since it normally takes some time before you are able to get an appointment, it is suggested that you make an appointment with your health care provider **as soon as possible** for your physical exam. This will eliminate a delay in processing your health form.

Vermont Tech Health Center, PO Box 500, Randolph Center, VT 05061

Phone: (802) 728-1212
Phone: (802) 728-1270

VERMONT TECH

Fax: (802) 728-1510
Fax: (802) 728-1784

Health Form

Vermont Technical College, PO Box 500, Health Center, Randolph Center, VT 05061
Phone 802-728-1270 or 802-728-1212 Fax 802-728-1784 or 802-728-1510

INSTRUCTIONS: This form must be completed, signed and submitted in order for you to begin the program.
The physical examination and immunization history must be completed and signed by your health care provider.

Student Name _____

Sex _____

Preferred Pronoun Mr. Mrs. Ms.

Student ID _____

Birthdate _____

Major & Start Term _____

Permanent Address:

Home phone _____

Cell phone _____

Work phone _____

Student email _____

Person to Notify In Case of Emergency:

Name _____

Relationship _____

Address

Home Phone _____

Cell Phone _____

Work Phone _____

My signature below indicates that:

- I consent to medical and nursing treatment by the health center staff.
- The information on this form is correct and complete to the best of my knowledge.
- I understand that my contacts with health and counseling services are held in confidence, but that confidentiality may be broken if a life is in danger.

Student Signature _____ Date ___ / ___ / ___

Parent/Guardian Signature _____

(Required if student is under 18 or if insurance is in parent's or guardian's name)

VERMONT TECH

Medical History

(To be completed by student)

Allergies: No Yes (if yes, list known allergies and type of reaction)

Medication	
Food	
Environmental	

Medications: No Yes (if yes, list all medications taken regularly. Include prescription, non-prescription medications, birth control, vitamins, minerals and supplements.) _____

Hospitalizations: Have you ever been hospitalized for any surgical or medical or psychiatric illness?

No Yes (If yes, specify diagnosis and date) _____

Have you received counseling or psychiatric care within the last six years? No Yes

Do you have or previously had the following (check those that apply):

- | | | |
|-----------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> asthma | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> back problems | <input type="checkbox"/> hearing loss | <input type="checkbox"/> HIV/AIDS or exposure to HIV/AIDS |
| <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> heart murmur | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> blood transfusion | <input type="checkbox"/> heart problem | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> breast pain or abnormality | <input type="checkbox"/> hepatitis/liver disease | <input type="checkbox"/> seizure |
| <input type="checkbox"/> broken bone | <input type="checkbox"/> hernia | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> (acne, eczema, other) |
| <input type="checkbox"/> chickenpox | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> stomach or bowel problems |
| <input type="checkbox"/> cholera | <input type="checkbox"/> joint or limb problem | <input type="checkbox"/> thyroid disease or disorder |
| <input type="checkbox"/> concussion/head injury | <input type="checkbox"/> kidney/bladder problems | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> counseling help | <input type="checkbox"/> malaria | <input type="checkbox"/> underweight |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> menstrual problems/abnormal pap | <input type="checkbox"/> urinary tract infection |
| <input type="checkbox"/> eye problems | <input type="checkbox"/> mental health issues | <input type="checkbox"/> yellow fever |
| <input type="checkbox"/> eating disorder | <input type="checkbox"/> (anxiety, depression, other) | <input type="checkbox"/> use tobacco products |
| <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> mononucleosis | <input type="checkbox"/> consume alcohol |
| <input type="checkbox"/> fainting | <input type="checkbox"/> overweight | |

Comments _____

Family History [siblings, parents, grandparents] (check those that apply):

- | | |
|-------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> heart attack or stroke |
| <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> depression/anxiety/mental health disease | <input type="checkbox"/> migraine headaches |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> thyroid disease |

Comments _____

Student Name (printed) _____

Student Signature _____ Date ___/___/___

Signature of Person Completing Form _____ Date ___/___/___

Reviewed by Health Care Provider Yes Date ___/___/___

VERMONT TECH

Physical Exam

(To be completed by health care provider)

Student name (Last, first, middle initial) _____

Date of Birth ___/___/___

Date of Exam ___/___/___ (within past 12 months)

Height _____ Weight _____ BP _____ Pulse _____

Vision Uncorrected: R _____ L _____ Vision Corrected: R _____ L _____

Normal	Abnormal		Please Comment on Abnormal Items
		General Development	
		Head, face, scalp, skull	
		Eyes	
		Ears, Nose /Sinus,Throat	
		Neck, Thyroid	
		Heart	
		Lungs	
		Breasts	
		Abdomen (include hernia)	
		Genitals (incl. testicular exam)	
		GYN (if indicated)	
		Extremities	
		Musculoskeletal	
		Lymph glands	
		Rectal (if indicated)	
		Neurological	
		Skin	

Is the student receiving medical care for a chronic condition or serious illness that may interfere with participation in program requirements? No Yes (if yes, comment below)

Do you have any concerns about the student participating in strenuous physical activity? No Yes (if yes, comment below)

Do you feel that there are any mental or emotional concerns to be aware of that may interfere with participation in program requirements? No Yes (if yes, comment below)

Comments:

Provider Signature _____ Date ___/___/___

VERMONT TECH

Immunizations

(To be completed by health care provider)

Student Name: _____

For Admission to College or Post-secondary School Vermont State Law requires proof of immunity to:

MMR: two vaccinations after the first birthday OR a positive titer;

VARICELLA: two vaccinations OR positive titer;

HEPATITIS: series of three vaccinations OR positive titer.

MENINGOCOCCAL DISEASE: one vaccine (for 1st year students living in dormitories or campus housing only).

You may not begin your program until complete immunization information is received.

REQUIRED FOR ALL STUDENTS:

	Date	Date	Date	TITER
MMR (Measles, Mumps, Rubella)	#1 _ / _ / _	#2 _ / _ / _	History of disease not accepted.	OR-Attach report
Hepatitis B Series	#1 _ / _ / _	#2 _ / _ / _	#3 _ / _ / _	OR-Attach report
Varicella (Chicken Pox)	#1 _ / _ / _	#2 _ / _ / _	History of disease not accepted.	OR-Attach report
Meningococcal (required for ALL 1 st yr. students living on campus) 2nd needed if first given before 16 years of age		_ / _ / _	_ / _ / _	NA
Tdap	_ / _ / _	<i>Must have received Tdap regardless of when last Td was given.</i>		

INITIAL TUBERCULOSIS SCREENING

PPD #1 & #2 or blood test **REQUIRED FOR: Health professions students**

Some students may need to undergo annual TB screening if required by their clinical site(s)

PPD #1 PLACED DATE:	PPD #1 READ DATE:	RESULT: _____ mm	PPD #2 PLACED DATE:	PPD #2 READ DATE:	RESULT: _____ mm	OR
_ / _ / _	_ / _ / _	<i>Record actual mm of induration. If no induration record "0"</i>	_ / _ / _	_ / _ / _	<i>Record actual mm of induration. If no induration record "0"</i>	Blood Test (quantiferon, T-spot, or other assay test) <i>Date: _ / _ / _</i>
All Health Professions Students	All Health Professions Students	Initials _____	<i>1-3 weeks after first PPD implantation</i>	Initials _____		

Chest x-ray (required if TB screening test is positive): Date: ___ / ___ / ___ Result: normal abnormal

Health Care Provider Signature _____ **Date** ___ / ___ / ___

Provider Printed Name, Address, and Phone #:
Provider contact information must be included for health form to be accepted.