Mandatory Health Form

ALL STUDENTS

COMPLETE AND SEND TO:
Vermont Technical College Health Center
PRIOR TO: August 1st

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 make a copy for your records, submit all information to Vermont Technical College, Health Center, PO Box 500, Randolph Center, VT 05061.

Due to problems with immunity in many college-age persons, and the close living and learning conditions on campus, 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 and learning on a college campus supports an environment where sharing of illness occurs, including communicable diseases such as Hepatitis B and Meningococcal disease. First year students living in residence halls are required to have the Meningococcal vaccination prior to admission. Others may also want to consider vaccination against meningococcal disease. Please discuss this with your Health Care Provider when you have your physical.

◆ 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.
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.

Name ________________________________

Sex__________________________________

Preferred Pronoun  Mr.  Mrs.  Ms.  □

Student ID ____________________________

Birthdate______________________________

Major & Start Term_____________________

Permanent Address:

____________________________________

____________________________________

____________________________________

Home phone___________________________

Cell phone____________________________

Work phone____________________________

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

<table>
<thead>
<tr>
<th>Medication</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
</tr>
</tbody>
</table>

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):

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

Comments
_________________________________________________________________________________

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

- alcoholism
- bleeding disorder
- cancer
- depression/anxiety/mental health disease
- diabetes
- heart attack or stroke
- high blood pressure
- high cholesterol
- migraine headaches
- thyroid disease

Comments
_________________________________________________________________________________

Student Name (printed) __________________________________________________

Student Signature___________________________________________________Date___/___/____

Signature of Person Completing Form____________________________________Date___/___/____

Reviewed by Health Care Provider Yes □ Date___/___/____
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 ________

Is the student receiving medical care for a chronic condition or serious illness?  
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?  
No □  Yes □ (if yes, comment below)

Comments:

Provider Signature ___________________________________________ Date ___/___/_____
Immunizations
(This Form Must 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 documented disease OR a positive titer;
VARICELLA: two vaccinations OR documented history of disease OR positive titer;
HEPATITIS B: series of three vaccinations or history of disease OR positive titer;
MENINGOCOCCAL DISEASE: one vaccine (for 1st year students living in dormitories or campus housing only).

You may not attend classes until completed immunization information is received.

REQUIRED FOR ALL STUDENTS:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date 1</th>
<th>Date 2</th>
<th>OR-ILLNESS</th>
<th>TITER</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (Measles, Mumps, Rubella)</td>
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<tr>
<td>Hepatitis B Series</td>
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<tr>
<td>Varicella (Chicken Pox)</td>
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<tr>
<td>Meningococcal</td>
<td></td>
<td></td>
<td>DOCUMENTED</td>
<td>NA</td>
</tr>
</tbody>
</table>

A Tdap must have been administered within the last ten years regardless of the interval since a Td may have been given.

TUBERCULOSIS SCREENING

PPD #1 & #2 REQUIRED FOR: ALL NURSING, RESPIRATORY, DENTAL HYGIENE & PARAMEDICINE STUDENTS

<table>
<thead>
<tr>
<th>PPD #1</th>
<th>PPD #2</th>
</tr>
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<tbody>
<tr>
<td>PLACED DATE:</td>
<td></td>
</tr>
<tr>
<td>READ DATE:</td>
<td></td>
</tr>
<tr>
<td>RESULT:</td>
<td>mm</td>
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<td>mm of induration.</td>
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<td>If no induration record &quot;0&quot;</td>
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<td>Initials</td>
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Blood test screening (quantiferon, T-spot, or other assay test) is acceptable for “Tuberculosis Screening”

ANNUAL

Date: __/__/___

Chest x-ray (required if tuberculin skin test is positive): Date: __/__/___ Result: ☐ normal ☐ abnormal

Health Care Provider Signature: ____________________________________________________________ Date __/__/___

Provider Printed Name, Address, and Phone:

January 2018 Rev