ALL ALLIED HEALTH STUDENTS

COMPLETE AND SEND HEALTH FORM TO:
CERTIFIED BACKGROUND
PRIOR TO: JULY 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 and that of the college community. Please submit all information to Certified Background, make a copy for your records, and submit a hard copy 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 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 State 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.

Nursing and respiratory 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.
INSTRUCTIONS: This form must be completed, signed and submitted in order for you to attend classes. The physical examination and immunization history must be completed and signed by your Health Care Provider.

Name ________________________________
Gender______________________________
Preferred Pronoun  Mr. ☐  Mrs. ☐  Ms. ☐
Student ID #________________________
Birth Date____________________________
Program of Study _____________________
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)
Medical History
(To Be Completed By Student)

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

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

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

Hospitalizations: No ☐ Yes ☐ Have you ever been hospitalized for any surgical or medical or psychiatric illness? (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)

Name of Student __________________________________________ Date of Birth ___/___/____ Date of Exam___/___/____

Last First MI (within past 12 months)

Height __________ Weight __________ BP __________ Pulse __________

Vision Uncorrected: R ________ L ________ Vision Corrected: R ________ L ________

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

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:** 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>Vaccination</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
<th>TITER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MMR</strong> (Measles, Mumps, Rubella)</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
<td>OR-Illness: <strong>/</strong>/____</td>
<td>OR-Attach report</td>
</tr>
<tr>
<td><strong>Hepatitis B Series</strong></td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
<td>OR-Attach report</td>
</tr>
<tr>
<td><strong>Varicella</strong> (Chicken Pox)</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
<td>OR-Illness: <strong>/</strong>/____ DOCUMENTED</td>
<td>OR-Attach report</td>
</tr>
<tr>
<td><strong>Meningococcal</strong> (required for ALL First 1st yr. students living on campus)</td>
<td><strong>/</strong>/____</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td><strong>Td ap</strong></td>
<td><strong>/</strong>/____</td>
<td>A Tdap must have been administered within the last ten years regardless of the interval since a Td may have been given.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TUBERCULOSIS SCREENING**

**PPD #1 & #2 REQUIRED FOR: ALL NURSING & RESPIRATORY STUDENTS**

<table>
<thead>
<tr>
<th>PPD #1</th>
<th>PPD #1</th>
<th>RESULT: mm</th>
<th><strong>REQUIRED</strong></th>
<th>PPD #2</th>
<th>PPD #2</th>
<th>PPD #2</th>
<th>RESULT: mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLACED DATE:</td>
<td>READING DATE:</td>
<td>0–3 weeks after first PPD implantation</td>
<td>Nursing &amp; Respiratory</td>
<td>PLACED DATE:</td>
<td>READING DATE:</td>
<td>0–3 weeks after first PPD implantation</td>
<td>0–3 weeks after first PPD implantation</td>
</tr>
<tr>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
<td>Initials________</td>
<td><strong>/</strong>/____</td>
<td><strong>/</strong>/____</td>
<td>Initials________</td>
<td><strong>/</strong>/____</td>
<td>Initials________</td>
</tr>
</tbody>
</table>

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 #: