VERMONT TECH

Mandatory Health Form

ALL ALLIED HEALTH STUDENTS: NURSING, DENTAL,

RESPIRATORY THERAPY AND PARAMEDICINE

COMPLETE AND SEND TO:
Castle Branch
and Vermont Tech Health Center
PRIOR TO: June 15

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.

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.

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

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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

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)

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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):

- ☐ 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___/___/____

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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 _____

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___/___/____

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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 a positive titer;
VARICELLA: two vaccinations 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 begin your program until completed 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 ALL1st yr. students living on campus) **2nd needed if first given before 16 years of age**		__/___/____	__/___/___	NA
Tdap	__/___/____	***Must have received Tdap regardless of when last Td was given.***		

TUBERCULOSIS SCREENING

PPD #1 & #2 REQUIRED FOR: **ALL NURSING, RESPIRATORY, DENTAL HYGEINE AND PARAMEDICINE STUDENT**

PPD #1 PLACED DATE: __/___/___ All Allied Health Students	**PPD #1** READ DATE: __/___/__ All Allied Health Students	**RESULT:** _____ **mm** *Record actual mm of induration. If no induration record "0"* Initials_____	**PPD #2** PLACED DATE: __/___/____ *1–3 weeks after first PPD implantation*	**PPD #2** READ DATE: __/___/____ Initials_____	**RESULT:** _____ **mm** *Record actual mm of induration. If no induration record "0"*	**ANNUAL** Blood test screening (quantiferon, T-spot, or other assay test) *Is acceptable for "Tuberculosis Screening"* *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 #:
Provider contact information must be included for health form to be accepted.