

# VERMONT TECH

## Mandatory Health Form

*ALL ALLIED HEALTH STUDENTS: NURSING, DENTAL, RADIOLOGIC SCIENCES, 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.

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

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):

- |                                                     |                                                                               |                                                                 |
|-----------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <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<br>(acne, eczema, other) |
| <input type="checkbox"/> cancer                     | <input type="checkbox"/> high blood pressure                                  | <input type="checkbox"/> stomach or bowel problems              |
| <input type="checkbox"/> chickenpox                 | <input type="checkbox"/> high cholesterol                                     | <input type="checkbox"/> thyroid disease or disorder            |
| <input type="checkbox"/> cholera                    | <input type="checkbox"/> joint or limb problem                                | <input type="checkbox"/> tuberculosis                           |
| <input type="checkbox"/> concussion/head injury     | <input type="checkbox"/> kidney/bladder problems                              | <input type="checkbox"/> underweight                            |
| <input type="checkbox"/> counseling help            | <input type="checkbox"/> malaria                                              | <input type="checkbox"/> urinary tract infection                |
| <input type="checkbox"/> diabetes                   | <input type="checkbox"/> menstrual problems/abnormal pap                      | <input type="checkbox"/> yellow fever                           |
| <input type="checkbox"/> eye problems               | <input type="checkbox"/> mental health issues<br>(anxiety, depression, other) | <input type="checkbox"/> use tobacco products                   |
| <input type="checkbox"/> eating disorder            | <input type="checkbox"/> mononucleosis                                        | <input type="checkbox"/> consume alcohol                        |
| <input type="checkbox"/> frequent ear infections    | <input type="checkbox"/> overweight                                           |                                                                 |
| <input type="checkbox"/> fainting                   |                                                                               |                                                                 |

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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Reviewed by Health Care Provider Yes  No  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 1<sup>st</sup> 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
<b>MMR</b> (Measles, Mumps, Rubella)	#1 _ / _ / _	#2 _ / _ / _	History of disease not accepted.	<b>OR-Attach report</b>
<b>Hepatitis B</b> Series	#1 _ / _ / _	#2 _ / _ / _	#3 _ / _ / _	<b>OR-Attach report</b>
<b>Varicella</b> (Chicken Pox)	#1 _ / _ / _	#2 _ / _ / _	History of disease not accepted.	<b>OR-Attach report</b>
<b>Meningococcal</b> (required for ALL 1 <sup>st</sup> yr. students living on campus) <b>2<sup>nd</sup> needed if first given before 16 years of age</b>		_ / _ / _	_ / _ / _	NA
<b>Tdap</b>	_ / _ / _	<b><i>Must have received Tdap regardless of when last Td was given.</i></b>		

### TUBERCULOSIS SCREENING

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

PPD #1 PLACED DATE:	PPD #1 READ DATE:	RESULT:  _____ mm	PPD #2 PLACED DATE:	PPD #2 READ DATE:	RESULT:  _____ mm	ANNUAL
_ / _ / _	_ / _ / _	<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 screening (quantiferon, T-spot, or other assay test) <i>Is acceptable for "Tuberculosis Screening"</i>
All Allied Health Students	All Allied Health Students	Initials _____	<i>1-3 weeks after first PPD implantation</i>	Initials _____		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.**