ALL ALLIED HEALTH STUDENTS

COMPLETE AND SEND 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, 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.

Health Center, PO Box 500, Randolph Center, VT 05061
Phone: (802) 728-1212 Fax: (802) 728-1510
Phone: (802) 728-1270 Fax: (802) 728-1784
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 ________________________________ Cell Phone # _____________________________

Gender ________________________________ Work Phone # ___________________________

Preferred Pronoun Mr. ☐ Mrs. ☐ Ms. ☐ Person to Notify In Case of Emergency:

Student ID # ___________________________ Name ________________________________

Birth Date ______________________________ Relationship __________________________

Program of Study _________________________ Address ______________________________

Permanent Address:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Home Phone # ____________________________ Cell Phone # __________________________

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

Comments _________________________________

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

- □ alcoholism
- □ heart attack or stroke
- □ diabetes
- □ bleeding disorder
- □ high blood pressure
- □ depression/anxiety/mental health disease
- □ cancer
- □ high cholesterol
- □ diabetes
- □ migraine headaches
- □ heart problem
- □ 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>MMR (Measles, Mumps, Rubella)</td>
<td>1/<strong><strong>/</strong></strong></td>
<td>2/<strong><strong>/</strong></strong></td>
<td>OR-Illness: 1/<strong><strong>/</strong></strong></td>
<td>OR-Attach report</td>
</tr>
<tr>
<td>Hepatitis B Series</td>
<td>1/<strong><strong>/</strong></strong></td>
<td>2/<strong><strong>/</strong></strong></td>
<td>3/<strong><strong>/</strong></strong></td>
<td>OR-Attach report</td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>1/<strong><strong>/</strong></strong></td>
<td>2/<strong><strong>/</strong></strong></td>
<td>OR-Illness: 1/<strong><strong>/</strong></strong> DOCUMENTED</td>
<td>OR-Attach report</td>
</tr>
<tr>
<td>Meningococcal (required for ALL First 1st yr. students living on campus)</td>
<td>1/<strong><strong>/</strong></strong></td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td>1/<strong><strong>/</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>Test</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD #1 PLACED DATE:</td>
<td>1/<strong><strong>/</strong></strong></td>
<td>All Allied Health Students</td>
</tr>
<tr>
<td>PPD #1 READ DATE:</td>
<td>1/<strong><strong>/</strong></strong></td>
<td>All Allied Health Students</td>
</tr>
<tr>
<td>RESULT: mm</td>
<td>mm</td>
<td>Record actual mm of induration. If no induration record “0”</td>
</tr>
<tr>
<td>PPD #2 REQUIRED Nursing &amp; Respiratory</td>
<td>1/<strong><strong>/</strong></strong></td>
<td>1–3 weeks after first PPD implantation</td>
</tr>
<tr>
<td>PPD #2 PLACED DATE:</td>
<td>1/<strong><strong>/</strong></strong></td>
<td>Initials______</td>
</tr>
<tr>
<td>PPD #2 READ DATE:</td>
<td>1/<strong><strong>/</strong></strong></td>
<td>Initials______</td>
</tr>
<tr>
<td>RESULT: mm</td>
<td>mm</td>
<td>Record actual mm of induration. If no induration record “0”</td>
</tr>
</tbody>
</table>

Chest x-ray (required if tuberculin skin test is positive): Date: 1/____/____ Result: [ ] normal [ ] abnormal

**Health Care Provider Signature** __________________________ Date 1/____/____

Provider Printed Name, Address, and Phone #: __________________________