VERMONT TECH

Mandatory Health Form

COMPLETE AND SEND ORIGINALTO:

Vermont Tech Health Center

KEEP COPIES FOR YOUR RECORDS

DUE DATE: August 1

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 AND UPLOADED TO CASTLEBRANCH.

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 the **Vermont Tech Health Center.** **Make a copy for your records** **before submitting the originals 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 with measles. If you have difficulty obtaining 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.

- **NOTE:** We suggest 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.

- **NOTE: The COVID-19 vaccine and booster(s) are required by Vermont Technical College. Students admitted to a Health Major, with approved medical or religious exemptions, will likely jeopardize their ability to be placed in a clinical setting due to the vaccination requirements of our clinical partner facilities. An approved exemption may lead to a consequence that interrupts or delays your education in a manner that is outside of the college's control.**

VERMONT TECH
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 your program. The physical examination and immunization history must be completed and signed by your health care provider.

Student Name ____________________________

Sex______________________________________

Preferred Prefix Mr.☐ Mrs.☐ Ms.☐ None ☐

Student ID _______________________________

Birthdate_________________________________

Major & Start Term________________________

Permanent Address:

____

____

____

Home phone______________________________

Cell phone________________________________

Work phone ______________________________

Student email_____________________________

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)

VERMONT TECH

Medical History - To be completed by student

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

Allergy	Specify	Reaction
Medication		
Food		
Environmental		

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

Have you had any hospitalizations? No☐ Yes ☐ (If yes, list dates and reasons for hospitalizations.)

Have you ever been hospitalized for psychiatric illness? No☐ Yes ☐ (If yes, list date and reasons.)

Have you received counseling or psychiatric care within the last six years? No☐ Yes ☐ (If yes, list why.)

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

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___/___/____

VERMONT TECH

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___/___/____

VERMONT TECH

Immunizations - To be completed by health care provider

Student Name (Printed):____

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 positive titer.
MENINGOCOCCAL DISEASE: one vaccine (for 1st year students living in on campus housing only).

You may not begin your program until complete immunization information is received.
REQUIRED FOR ALL STUDENTS:

Vaccine	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 ALL 1st yr. students living on campus) **2nd needed if first given before 16 years of age**		#1 ___/___/____	#2 ___/___/___	NA
Tdap	___/___/___	***Must have received Tdap regardless of when last Td was given.***		
COVID-19 Vaccine(s)	#1 ___/___/___ Brand __________	#2 ___/___/___ Brand __________ N/A ☐	**COVID-19 Booster**	#1 ___/___/___ Brand __________

TUBERCULOSIS SCREENING

PPD #1 & #2 or blood test REQUIRED for Health Professions Students

PPD #1	**RESULT:**	**PPD #2 –** *1–3 weeks after first PPD placed*	**RESULT:**	**OR Blood Test**
Date Placed: ___/___/___	_______ **mm**	Date Placed: ___/___/____	_______ **mm**	(quantiferon, T-spot, or other assay test)
PPD #1 Date Read: ___/___/___	*Record actual mm of induration. If no induration record "0"* Initials_______	**PPD #2** Date Read: ___/___/____	*Record actual mm of induration. If no induration record "0"* Initials_______	Date: ___/___/___ Result:__________

Chest x-ray (required if TB screening 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.

January 2022 Rev