# Health Services Student Medical Form

Full Name: _____ Date Submitted: _____

## Student Medical Form for

(Please check **one**)

- ☐ Associate Degree Nursing
- ☐ Dental Hygiene
- ☐ Electroneurodiagnostic Technology
- ☐ Emergency Medical Science
- ☐ Health Information Technology
- ☐ Phlebotomy
- ☐ Pharmacy Technician
- ☐ Polysomnography
- ☐ Radiography
- ☐ Respiratory Therapy
- ☐ Surgical Technology

It is very important that you read and follow all directions in this packet. Make sure all information is completed before submitting your packet. Partial packets **will not** be accepted. Thank you.

Copies of records may be submitted, but all information must be completed and a signature is required by healthcare provider on all forms.

**Please make a copy of these forms for your records**.

## Family and Personal Health History

(Please Print in black ink)

### Personal Information

To be completed by student

Last Name _____ First Name _____ Middle/Maiden _____

CVCC ID Number _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Date of Birth (mo/day/yr) _____ Gender ☐ M ☐ F

Marital Status ☐ S ☐ M ☐ Other Email _____

Hospital/Health Insurance _____

Address of Insurance _____ Phone Number (___) _____

Name of Policy Holder _____ Employer _____

Policy or Certificate Number _____ Group Number _____

Is this an HMO/PPO/Managed Plan? Yes No

### Emergency Contact Information

Name of Contact _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone Number (___) _____

### Health History Information

The following health history is confidential, does not affect your admission status, and, except in an emergency or by court order, will not be released without your written permission. Please attach additional sheets for any items that require explanation.

**Family History**

Has any person, related by blood, had any of the following:

| Condition | Yes | No | Relationship |
|---|---|---|---|
| High Blood Pressure | | | |
| Stroke | | | |
| Heart Attack before age 55 | | | |
| Blood or clotting disorder | | | |
| Cholesterol or blood fat disorder | | | |
| Diabetes | | | |
| Glaucoma | | | |
| Cancer (Type) | | | |

| Condition | Yes | No | Relationship |
|---|---|---|---|
| Alcohol/drug problems | | | |
| Psychiatric illness | | | |
| Suicide | | | |

If any person, related by blood, had cancer, please list the type: _____

**Personal History**
Height _____ Weight _____

Have you ever had or have you now:
(If yes, indicate the year of first occurrence.)

| Condition | Yes | No | Year |
|---|---|---|---|
| High blood pressure | | | |
| Rheumatic fever | | | |
| Heart trouble | | | |
| Pain or pressure in chest | | | |
| Shortness of breath | | | |
| Asthma | | | |
| Pneumonia | | | |
| Chronic cough | | | |
| Head or neck radiation treatments | | | |
| Tumor or cancer | | | |
| Malaria | | | |
| Thyroid trouble | | | |
| Diabetes | | | |
| Serious skin disease | | | |
| Mononucleosis | | | |
| Hay fever | | | |
| Allergy injection therapy | | | |
| Arthritis | | | |
| Concussion | | | |
| Frequent or severe headache | | | |
| Dizziness or fainting spells | | | |
| Severe head injury | | | |
| Paralysis | | | |
| Disabling depression | | | |
| Excessive worry or anxiety | | | |
| Ulcer (duodenal or stomach) | | | |
| Intestinal trouble | | | |

| Condition | Yes | No | Year |
|---|---|---|---|
| Pilonidal cyst | | | |
| Frequent vomiting | | | |
| Gall bladder trouble or gallstones | | | |
| Jaundice or hepatitis | | | |
| Rectal disease | | | |
| Severe or recurrent abdominal pain | | | |
| Hernia | | | |
| Fatigue | | | |
| Anemia or sickle cell anemia | | | |
| Eye trouble besides needing glasses | | | |
| Bone, joint, or other deformity | | | |
| Knee problems | | | |
| Recurrent back pain | | | |
| Neck injury | | | |
| Back injury | | | |
| Broken bone | | | |
| Kidney infection | | | |
| Bladder infection | | | |
| Kidney stones | | | |
| Protein or blood in urine | | | |
| Hearing loss | | | |
| Sinusitis | | | |
| Severe menstrual cramps | | | |
| Irregular periods | | | |
| Sexually transmitted Disease | | | |
| Blood transfusion | | | |
| Alcohol use | | | |
| Drug use | | | |
| Anorexia/bulimia | | | |
| Smoke 1+ pack cigarettes/week | | | |
| Regular exercise | | | |
| Wear seat belt | | | |
| Other | | | |

If you answered yes for Tumor or Cancer, please specify. _____

If you answered yes for Broken Bone, please specify. _____

If you answered yes for Other, please specify. _____

**Medications**

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

| Number | Name | Use | Dosage |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |

**Allergy/Adverse Reaction Information**

Check each item “Yes” or “No.” Every item checked “Yes” must be fully explained in the space to the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

| Allergies/Adverse Reaction To | Yes | No | Names | Explanation of Symptoms |
|---|---|---|---|---|
| Antibiotics | | | | |
| Pain Medication | | | | |
| Latex | | | | |
| Insect Bites | | | | |
| Food | | | | |

**Additional Questions**

| Question | Yes | No | Explanation |
|---|---|---|---|
| Do you have any conditions or disabilities that limit your physical activity? (If yes, please describe.) | | | |
| Have you ever been a patient in any type of hospital? (specify when, where, and why.) | | | |
| Has your academic career been interrupted due to physical or emotional problems? (Please explain.) | | | |

| Question | Yes | No | Explanation |
|---|---|---|---|
| Is there loss of seriously impaired function of any paired organs? (Please describe.) | | | |
| Other than for routine check-up, have you seen a physician or healthcare professional in the past six months? (Please describe.) | | | |
| Have you ever had serious illness or injuries other than those already noted? (Specify when and where and give details.) | | | |

## Student Statement

Important information. Please read and complete. Statement is to be completed by student (or parent/guardian, if student is under age 18).

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (child's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

Signature of Student _____ Date _____

Signature of Parent/Guardian (if student is under 18) _____ Date _____

## Guidelines for Completing Immunization Record

Important – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit. Immunization records must include name, date of birth, **and** vaccine administration (must include the month, day, and year).

Acceptable records of your immunizations must be obtained from any of the following:

- High School Records – These may contain some, but not all, of your immunization information. Contact Student Services for help, if needed. Your immunization records do not automatically transfer. You must request a copy.
- Personal Shot Records – Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department
- Military Records or WHO (World Health Organization Documents)
- Previous College or University – Your immunization records do not transfer automatically. You must request a copy.

### Required Immunizations According to Age

Students 17 Years of Age and Younger

- DTP, Tdap, or Td booster – 3 doses
- Polio – 3 doses
- Measles – 2 doses
- Mumps – 1 dose
- Rubella – 1 dose

Students Born in 1957 or Later and 18 Years of Age or Older

- DTP, Tdap, or Td booster – 3 doses
- Polio – 0 doses
- Measles – 2 doses
- Mumps – 1 dose
- Rubella – 1 dose

Students Born Before 1957

- DTP, Tdap, or Td booster – 3 doses
- Polio – 0 doses
- Measles – 0 doses
- Mumps – 0 dose
- Rubella – 1 dose

Students 50 Years of Age and Older

- DTP, Tdap, or Td booster – 3 doses
- Polio – 0 doses
- Measles – 0 doses
- Mumps – 0 dose
- Rubella – 0 dose

International Students

Vaccines are required according to age, as listed above. Additionally, international students are required to have TB skin test and negative result within 6 months prior to the first day of classes (chest x-ray required if test is positive).

**Notes**

- DTP (Diphtheria, Tetanus, Pertussis), Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, and Pertussis): One Tdap as an adult, then Td booster every ten years.
- Measles: One dose on or after 12 months of age; second at least 30 days later. Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age.
- Two measles doses if entering college for the first time after July 1, 1994.
- Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age.
- Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of varicella, measles, rubella or mumps disease, even from a physician, is not acceptable.
- Attach lab report
- Mantoux test **only** will be accepted. Two-step TB testing must include (2) separate TB Mantoux test within 6 months of admission to the program. There must be a minimum of **7** days between the first and second test administration.

**Please Note:** Some programs may require different testing guidelines determined by program clinical sites. You will be notified of these guidelines at the time of your acceptance into the program.

## Immunization Record

Print in black ink. Completed by Physician or Clinic. A complete immunization form may be attached to this form.

Last Name _____ First Name _____ Middle/Maiden _____

Date of Birth (mo/day/yr) _____ CVCC ID Number _____

**Required Immunizations**

| Immunization | Dose 1 (Mo/Day/Year) | Dose 2 (Mo/Day/Year) | Dose 3 (Mo/Day/Year) | Dose 4 (Mo/Day/Year) |
|---|---|---|---|---|
| DTP or Td | | | | |
| Tdap (one dose as adult) then Td every 10 years | | | | |
| Polio | | | | |
| MMR (after 1st birthday) Proof of 2 | | | | |
| MR (after 1st birthday) | | | | |
| Measles (after 1st birthday) | | | | |
| Mumps | | | | |
| Rubella | | | | |
| Varicella (chicken pox) Proof of 2 or immunity by positive blood titer | | | | |
| Hepatitis B (series only) OR | | | | |
| Hepatitis A/B (combined series) OR | | | | |
| Sign school and/or hospital wavier | | | | |

**Immunization Titer Dates**

| Immunization | Titer Date | Results |
|---|---|---|
| Measles | | |
| Mumps | | |
| Rubella | | |
| Varicella | | |
| Hepatitis B | | |

**2-Step Tuberculin (PPD) Skin Test**
(within last 6 months)

| Step | Date Read | mm Induration |
|---|---|---|
| 1 | | |
| 2 | | |

Chest X-Ray, if positive PPD (date) _____

Results _____

Treatment, if applicable _____

## Strongly Recommended

The following immunizations are strongly recommended for health care students. Some hospitals may require them.

| Immunization | Dose 1 (Mo/Day/Year) | Dose 2 (Mo/Day/Year) | Dose 3 (Mo/Day/Year) | Dose 4 (Mo/Day/Year) |
|---|---|---|---|---|
| Haemophilus influenza type b OR | | | | |
| Sign school and/ or hospital waiver | | | | |
| Pneumococcal | | | | |
| Hepatitis A series only | | | | |
| Meningococcal | | | | |
| Other | | | | |

Signature or Clinic Stamp **Required**:

Signature of Physician/PA/Nurse Practitioner _____ Date _____

Print Name of Physician/PA/Nurse Practitioner _____

Phone Number (___)_____ City/State/Zip _____

## Physical Examination

(Please print in black ink.)
To be completed and signed by physician or clinic.

A physical examination is required by some schools and/or programs. Consult your college or department for specific requirements. If required, it must be completed in black ink and signed by a physician or clinic.

Last Name _____ First Name _____ Middle/Maiden _____

Date of Birth (mo/day/yr) _____ CVCC ID Number _____

Address _____ City _____ State _____ Zip _____

Phone Number _____

Height _____ Weight _____ TRP _____/_____/_____ BP _____/_____

### Vision, if required

Corrected: Right 20/____ Left 20/____

Uncorrected: Right 20/____ Left 20/____

Color Vision: _____

### Hearing, if required

Gross: Right _____ Left _____

15 ft: Right _____ Left _____

### Abnormalities

| Are there abnormalities? | Normal | Abnormal | Description (attach additional sheets, if necessary) |
|---|---|---|---|
| Head, ear, nose, throat | | | |
| Eyes | | | |
| Respiratory | | | |
| Cardiovascular | | | |
| Gastrointestinal | | | |
| Hernia | | | |
| Genitourinary | | | |
| Musculoskeletal | | | |
| Metabolic/Endocrine | | | |
| Neuropsychiatric | | | |
| Skin | | | |
| Mammary | | | |

Is there loss of seriously impaired function of any paired organs? Yes ☐ No ☐
Explain _____

Is student under treatment for any medical or emotional condition? Yes ☐ No ☐
Explain _____

Is student physically and emotionally healthy? Yes ☐ No ☐
Explain _____

**For Students Admitted to a Health Service Program**
This section **must be completed**. Non-completion will result in returning the health form to the student to return to healthcare provider for completion.

Based on my assessment of this student's physical and emotional health and with the understanding of the student's selected healthcare field on _____(date), he/she appears able to participate in the activities of a health profession in a clinical setting.

Yes ☐ No ☐ If no, please explain _____

_____

Signature of Physician/PA/Nurse Practitioner _____ Date _____

Print Name of Physician/PA/Nurse Practitioner _____

Address _____ City _____ State _____ Zip _____

Phone Number (___)_____