



VSC Health Form

Vermont State College Health Form

Castleton State College, 248 South Street, Castleton VT 05735

Johnson State College, 337 College Hill, Johnson VT 05696

Lyndon State College, PO Box 919, Lyndonville VT 05851

Vermont Technical College, PO Box 500 Randolph Center VT 05061

All students must send completed Health Form, a front and back copy of your insurance card and immunization history to the Health Center at the site you will be attending.

Instructions

This form must be completed, signed, and submitted in order for you to register for classes.

The physical examination and immunization history must be completed and signed by your Health Care Provider.

Name _____

Social Security Number _____ - _____ - _____

Birth Date _____

Program of Study _____

Permanent Address

Telephone

Home Number _____ - _____ - _____

Cell Number _____ - _____ - _____

Work Number _____ - _____ - _____

NO HEALTH INSURANCE? Check Here _____

If you do not have Health Insurance and are a full-time student you will be required to purchase the State College's student health insurance policy.

Health Insurance Company

Policy Number _____

Person to Notify In Case of Emergency

Name _____

Relationship _____

Address

Telephone

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.)

Student Medical History

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.)

Medications _____

Hospitalizations

No Yes Have you ever been hospitalized for any surgical or medical or psychiatric illness?
If yes, specify diagnosis and date:

No Yes Have you received counseling or psychiatric care within the last six years?
If yes, please specify:

Do you have or previously had the following (Check those that apply.)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Attention deficit disorder | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Joint or limb problem | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Kidney/bladder problems | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Malaria/yellow fever | <input type="checkbox"/> Skin problems (acne, etc) |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Fainting | <input type="checkbox"/> Menstrual problems/abnormal pap | <input type="checkbox"/> Stomach or bowel problems |
| <input type="checkbox"/> Breast pain or abnormality | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Mental health issues (anxiety, depression, other) | <input type="checkbox"/> Thyroid disease or disorder |
| <input type="checkbox"/> Broken bone | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Overweight | <input type="checkbox"/> Underweight |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Heart problem | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Hepatitis/liver disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Use tobacco/other substances |
| <input type="checkbox"/> Concussion/head injury | <input type="checkbox"/> Hernia | | <input type="checkbox"/> Consume alcohol |
| <input type="checkbox"/> Counseling help | <input type="checkbox"/> High blood pressure | | |

Have you ever been hospitalized for any surgical or medical or psychiatric illness? (If yes, specify diagnosis and date.)

Diagnosis _____

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 Signature _____ Date ____ / ____ / ____

Signature of Person Completing Form _____ Date ____ / ____ / ____
(If other than student.)

Reviewed by Health Care Provider Yes Date ____ / ____ / ____



Physical Form

To Be Completed By Health Care Provider

Date of Exam ___/___/_____ (Within past 12 months.)

Name of Student _____ Date of Birth ___/___/_____

LAST FIRST MI

Height _____ BP _____ Vision Uncorrected: R _____ L _____

Weight _____ Pulse _____ Vision Corrected: R _____ L _____

NORMAL	ABNORMAL	PLEASE COMMENT ON ABNORMAL ITEMS
<input type="checkbox"/>	<input type="checkbox"/>	General Development
<input type="checkbox"/>	<input type="checkbox"/>	Head, face, scalp, skull
<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose/Sinus, Throat
<input type="checkbox"/>	<input type="checkbox"/>	Neck, Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Heart
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	Breasts
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (include hernia)
<input type="checkbox"/>	<input type="checkbox"/>	Genitals (incl. testicular exam)
<input type="checkbox"/>	<input type="checkbox"/>	GYN (if indicated)
<input type="checkbox"/>	<input type="checkbox"/>	Extremities
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Lymph glands
<input type="checkbox"/>	<input type="checkbox"/>	Rectal (if indicated)
<input type="checkbox"/>	<input type="checkbox"/>	Neurological
<input type="checkbox"/>	<input type="checkbox"/>	Skin

If yes, please comment below.

- No Yes Is the student receiving medical care for a chronic condition or serious illness?
- No Yes Do you have any concerns about the student participating in competitive physical activity?
- No Yes Do you feel that there are any mental or emotional concerns to be aware of?

Comments

Provider Signature _____ Date ___/___/_____

Vaccines and Immunizations

To Be Completed By Health Care Provider

Vermont State Law requires proof of vaccinations OR documented disease OR a positive titer. You may not register for classes until completed Health Forms and immunization is received by the college Health Center.

Required Immunizations

MMR (Measles, Mumps, Rubella)

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

OR

Measles Titer Date ____ / ____ / _____

Mumps Titer Date ____ / ____ / _____
(Attach copy of lab reports)

Rubella Titer Date ____ / ____ / _____

Rabies Vaccine Series (for Vet Tech Students)

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

Date 3 ____ / ____ / _____

Polio Vaccine Series (for all Nursing Students)

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

Date 3 ____ / ____ / _____

Polio Titer

Date 1 ____ / ____ / _____

(Attach copy of all lab reports)

Td (Tetanus/Diphtheria)

Date ____ / ____ / _____

OR

Tdap (Tetanus/Diphtheria/Pertussis)

Date ____ / ____ / _____

Hepatitis B Series

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

Date 3 ____ / ____ / _____

Varicella (Chicken Pox)

Date 1 ____ / ____ / _____

Date 2 ____ / ____ / _____

OR

Date of Disease ____ / ____ / _____

OR

Date of Titer ____ / ____ / _____

(Attach copy of lab report or required documentation form)

Meningococcal

Date ____ / ____ / _____

Tuberculosis Screening (PPD is required for all Castleton students.)

1. Has the student lived outside the following countries: No Yes
USA, Canada, Jamaica, Virgin Islands, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, UK, Samoa, Australia, New Zealand, Saint Lucia, Saint Kitts and Nevis.
2. Has the student been in close contact with someone with tuberculosis? No Yes
3. Has the student resided or worked in a prison, homeless shelter, nursing home, or hospital? No Yes
4. Does the student have cancer, leukemia, diabetes, HIV/AIDS, history of IV drug use or take immunosuppressive medication such as prednisone? No Yes

If any answers were YES, PPD skin test is required.

Date given ____ / ____ / _____

Date read ____ / ____ / _____

Result ____ / ____ / _____

Chest x-ray

(Required if tuberculin skin test is positive.)

Abnormal Normal

Date ____ / ____ / _____

Health Care Provider Signature _____ Date ____ / ____ / _____

Health Care Provider Printed Name _____

Provider Address, Phone and Fax _____