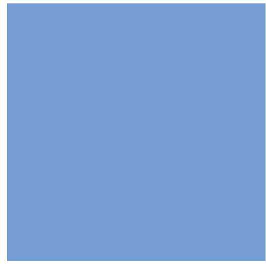

VSC Health Form

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.)

Revised 1/08

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.)

- ☐ Asthma
- ☐ Attention deficit disorder
- ☐ 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/yellow fever
- ☐ Menstrual problems/abnormal pap
- ☐ Mental health issues (anxiety, depression, other)
- ☐ Mononucleosis
- ☐ Overweight
- ☐ Pneumonia
- ☐ HIV/AIDS
- ☐ Rheumatic fever
- ☐ Scoliosis
- ☐ Seizure
- ☐ Skin problems (acne, etc)
- ☐ Stomach or bowel problems
- ☐ Thyroid disease or disorder
- ☐ Tuberculosis
- ☐ Underweight
- ☐ Urinary tract infection
- ☐ Use tobacco/other substances
- ☐ Consume alcohol

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):

- ☐ 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 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
☐	☐	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	

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 Titier Date ____ / ____ / ________

Mumps Titier Date ____ / ____ / ________

(Attach copy of lab reports)

Rubella Titier 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 ________________________________

____