Student Medical Form

VGCC

VANCE-GRANVILLE COMMUNITY COLLEGE

STUDENT MEDICAL FORM
VANCE-GRANVILLE COMMUNITY COLLEGE

INSTRUCTIONS FOR COMPLETING STUDENT MEDICAL FORM

1. Complete the four-page insert:
    - Physical Examination
    - Immunization Record
    - Report of Medical History
    - Family & Personal Health History

2. Return/submit form as instructed by Program Head/Department Chair in your acceptance letter.

3. If you have questions about the form, please call the Program Head/Department Chair for the program you are entering.

REPORT OF MEDICAL HISTORY (Please print in black ink) To be completed by student

LAST NAME FIRST NAME MIDDLE NAME * SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo./day/yr.) _____ GENDER ❑ MALE ❑ FEMALE MARITAL STATUS ❑ S ❑ M ❑ OTHER

CLASS YOU ARE ENTERING (circle):
FR. SO. JR. SR. GRAD. PROF.

PREVIOUSLY ENROLLED HERE ❑ YES ❑ NO
IF YES, DATES _____

SEMESTER ENTERING (circle) FALL SPRING
SUMMER 1 SUMMER 2 OTHER YEAR 20 ____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

NAME OF POLICY HOLDER * SOCIAL SECURITY NUMBER EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER IS THIS AN HMO/PPO/MANAGED CARE PLAN? ❑ YES ❑ NO

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

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

FAMILY & PERSONAL HEALTH HISTORY (Please print in black ink) To be completed by student

Has any person related by blood had any of the following?

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer — type:			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT _____ WEIGHT _____

Have you ever had, or do you now have any of the following: (please check at right of each item, and if yes, year of first occurrence).

	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 (specify)			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion			
Frequent or severe headaches			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble except need for glasses			
Bone, joint or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			

	Yes	No	Year
Kidney stone			
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			
Regularly exercise			
Wear seat belt			
Other (specify)			

Please list any drugs, medicines, birth control pill, vitamins and minerals (prescription or nonprescription) you use and indicate how often you use them.

Name _____ Use_____ Dosage _____ Name _____ Use_____ Dosage _____

Name _____ Use_____ Dosage _____ Name _____ Use_____ Dosage _____

Name _____ Use_____ Dosage _____ Name _____ Use_____ Dosage _____

Name _____ Use_____ Dosage _____ Name _____ Use_____ Dosage _____

* Provision of Social Security Number is voluntary, is requested sole for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

FAMILY & PERSONAL HEALTH HISTORY - CONTINUED (Please print in black ink) To be completed by student

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on 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.

Adverse Reactions to:	**Yes**	**No**	**Explanation**
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	**No**	**Explanation**
Do you have any conditions or disabilities that limit your physical activities? (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.)			
Is there loss or seriously impaired function of any paired organs? (Please describe.)			
Other than for a routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe.)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details.)			

IMPORTANT INFORMATION…PLEASE READ AND COMPLETE

STATEMENT BY STUDENT OR PARENT/GUARDIAN, IF STUDENT IS UNDER AGE 18:

(A) 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 (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (son/daughter) that may be advised or recommended by the physicians of the student health service. (Not applicable to community colleges.)

(C) I am aware that the student health service does charge for some services, and that I may be billed through the university cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. (Not applicable to community colleges.)

Signature of Student _____ Date _____

Signature of Parent/Guardian, if student under age 18 _____ Date _____

Vance-Granville Community College
P.O. Box 917
Henderson, NC 27536
(252) 492-2061

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, the results must be completed in black ink and signed by a physician or clinic.

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH (mo./day/year)	* SOCIAL SECURITY NUMBER

PERMANENT ADDRESS	CITY	STATE	ZIP CODE	AREA CODE/PHONE NUMBER

HEIGHT _____ WEIGHT _____ TPR _____/_____/_____ BP _____/_____

Are There Abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

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

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
Explain _____

D. Is student physically and emotionally healthy? Yes _____ No _____
Explain _____

• Required for Health Sciences Programs •

Based on my assessment of this student's physical and emotional health 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/Physician Assistant/Nurse Practitioner

Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Area Code / Phone Number

Office Address City State Zip Code

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IMMUNIZATION RECORD	(Please print in black ink) To be completed and signed by physician or clinic A complete immunization record from a physician or clinic may be attached to this form.

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH (mo./day/year)	* SOCIAL SECURITY NUMBER

SECTION A: REQUIRED IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
TDAP (within 10 years)				
MMR (2 doses required) or				
Measles (2 doses or positive titer)				**** Titer Date & Result
Mumps (2 doses or positive titer)				**** Titer Date & Result
Rubella (2 doses or positive titer)				**** Titer Date & Result
Hepatitis B series (3 doses or positive titer or declination signed below)				**** Titer Date & Result
Varicella (chicken pox) (2 doses or positive titer)				**** Titer Date & Result
Tuberculin (PPD) Test (within 12 months) Date read mm induration				
Chest x-ray, if positive PPD Date Results				
Treatment, if applicable Date				

DECLINATION FOR HEPATITIS B SERIES

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been strongly encouraged to be vaccinated with hepatitis B vaccine. However, I decline hepatitis B vaccination at this time. I understand that by declining to make arrangements and to receive this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other infectious materials and I want to be vaccinated with hepatitis B vaccine, I may make arrangements to do so.

Student's Signature _____ Date _____

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner _____ Date _____

Print Name of Physician/Physician Assistant/Nurse Practitioner _____ Area Code / Phone Number _____

Office Address _____ City _____ State _____ Zip Code _____

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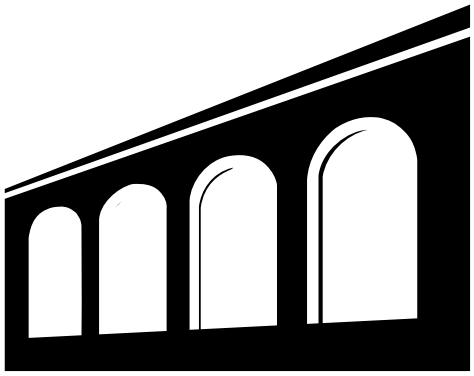
** Must repeat Rubella (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

*** Only laboratory proof of rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from physician, is not acceptable.

**** Attach lab report.



Rev. 4/15