STUDENT HEALTH FORM

Banner ID: _____

Tunxis Community College
Education That Works For a Lifetime

Board of Regents for Higher Education

TUNXIS COMMUNITY COLLEGE, Attention: Cheryl Conaty, R.N.
271 Scott Swamp Road • Farmington, Connecticut 06032-3187

☐ **CMAA**
☐ **RMA**
☐ **CNA**
☐ **PHLEBOTOMY**

APPLICANT: Please print. Complete this side.
EXAMINING PHYSICIAN: Please print. Complete reverse side ASAP and return to address above.

APPLICANT

Name (last, first, middle) | Social Security # ☐☐☐☐

Permanent Home Address (number & street, city or town, state, zip code) | Telephone # (include area code)

Sex: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Date of Birth (month, day, year)

IN CASE OF EMERGENCY

Name (last, first, middle) | Relationship

Address (number & street, city or town, state, zip code) | Telephone # (include area code)

FAMILY HISTORY

Has any family member ever had the following:

☐ CANCER ☐ TUBERCULOSIS ☐ DIABETES ☐ ALLERGY OR ASTHMA ☐ EPILEPSY OR CONVULSIONS ☐ STROKE
☐ HEART DISEASE ☐ NERVOUS OR MENTAL ILLNESS ☐ MIGRAINE HEADACHES ☐ HIGH BLOOD PRESSURE

PERSONAL HISTORY

Have you ever had:	YES	NO		Have you ever had:	YES	NO	Have you ever had:	YES	NO
1. MEASLES	☐	☐	ITEMS 6-15 •	6. RHEUMATIC FEVER	☐	☐	11. CONVULSIONS	☐	☐
2. MUMPS	☐	☐	*All "Yes" answers must be explained below.*	7. HEART DISEASE	☐	☐	12. HIGH BLOOD PRESSURE	☐	☐
3. CHICKEN POX	☐	☐		8. HEART MURMUR	☐	☐	13. ALLERGIES	☐	☐
4. GERMAN MEASLES	☐	☐		9. DIABETES	☐	☐	14. FAINTING SPELLS	☐	☐
5. WHOOPING COUGH	☐	☐		10. TUBERCULOSIS	☐	☐	15. HEPATITIS	☐	☐

QUESTION	YES	NO	If "YES," please explain:
1. Have you ever had any operations and/or significant injuries?	☐	☐	
2. Do you have any physical impairment? (eg., paralysis, loss of hearing, vision)	☐	☐	
3. Have you had any emotional problems requiring treatment?	☐	☐	
4. Do you take any medications regularly?	☐	☐	
5. Have you reacted unfavorably to any medication? (eg., penicillin, aspirin)	☐	☐	
6. Has your physical activity ever been limited?	☐	☐	

SIGNATURE(S)

Date | Student's Signature (if under the age of 18, parent or guardian must also sign)

PERMISSION TO TREAT MINOR INJURY OR ILLNESS

I hereby grant permission to the medical staff of the college to render or secure proper treatment for my daughter, son or ward (named above). It is my understanding that I will be notified in case of any illness or injury of major proportion. In addition, I grant permission to the college physician to hospitalize this student in case of a surgical emergency requiring the administration of anaesthesia provided that the physician is unable to communicate with me and that, in his/her judgement, delay might endanger the life of the student.

Date | Parent's or Guardian's Signature

THIS SIDE TO BE COMPLETED BY EXAMINING PHYSICIAN ONLY

IMMUNIZATION HISTORY

ALL students are required to provide proof of either immunization or laboratory results of immunity. **TITERS** chosen for proof of immunization **MUST BE POSITIVE** and the **LABORATORY REPORT MUST ACCOMPANY THIS FORM**.

MEASLES 1st dose: _____ or Titer › Immune? ❑ YES ❑ NO
date/given on or after 1st birthday & after Jan. 1, 1969 ***Laboratory report must be attached to form.***

MEASLES 2nd dose: _____
date/given after Jan. 1, 1980

MUMPS: _____ or Titer › Immune? ❑ YES ❑ NO
date/given on or after 1st birthday ***Laboratory report must be attached to form.***

RUBELLA: _____ or Titer › Immune? ❑ YES ❑ NO
date/given on or after 1st birthday ***Laboratory report must be attached to form.***

POLIO: _____ or Titer › Immune? ❑ YES ❑ NO
date(s) of immunization ***Laboratory report must be attached to form.***

VARICELLA (Chicken Pox): _____ or Titer › Immune? ❑ YES ❑ NO
date(s) of immunization ***Laboratory report must be attached to form.***

Td (TETANUS booster): _____
date/must have been given within the last 10 years

FLU VACCINE (spring and fall applicants only) _____

HEPATITIS B SERIES: _____ _____ _____ Risk Form _____
date/1st dose date/2nd dose date/3rd dose intial

***TUBERCULIN TEST/PPD** (Mantoux or QFT-G): _____ _____ _____
date given date read results

* Date no earlier than March 1 of the year of admission to the program. A student with a positive PPD or previous inoculation with BCG must provide a chest x-ray report with appropriate medical follow-up.

PHYSICAL EXAMINATION

HEIGHT	WEIGHT	COMMENTS and RECOMMENDATIONS

EYES	VISION (R)	(L)	CORRECTION (R)	(L)
EARS	DRUMS	HEARING (R)		(L)
NASOPHARYNX	SEPTUM		TONSILS	
TEETH	OCCLUSION	CARIES		GINGIVITIS
NECK	CERVICAL NODES		THYROID	
CHEST	BREASTS		LUNGS	
	HEART (Rate)	(Rhythm)	(Murmurs)	(Blood Pressure)
ABDOMEN	LIVER	SPLEEN		HERNIA
SKELETAL	SPINE	JOINTS		FEET
CNS	REFLEXES			
LABORATORY	URINALYSIS		HEMATOCRIT OR HEMOGLOBIN	

I believe this student is able to participate in a full academic and clinical program (unless otherwise noted above).

DATE	EXAMINING PHYSICIAN'S SIGNATURE	ADDRESS	TELEPHONE
	M.D.		