

**Student Medical Form**

**For**

**Southwestern Community College**

**Health Science Programs**



**Completed Form Must Be Returned  
As Instructed in the Accompanying Letter**

**REPORT OF MEDICAL HISTORY**

(Please print in black ink)

To be completed by student

LAST NAME (print)	FIRST NAME	MIDDLE/MAIDEN NAME	SOCIAL SECURITY NUMBER		
PERMANENT ADDRESS		CITY	STATE	ZIP CODE	AREA CODE/PHONE NUMBER
DATE OF BIRTH (mo/day/yr) _____					
SCC PROGRAM _____					

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? <input type="checkbox"/> YES <input type="checkbox"/> NO		

NAME OF PERSON TO CONTACT IN CASE OF 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		Yes	No	Relationship		Yes	No	Relationship		
High blood pressure				Cholesterol or blood fat disorder				Cancer (type):					
Stroke					Diabetes					Alcohol/drug problems			
Heart attack before age 55					Glaucoma					Psychiatric illness			
Blood or clotting disorder										Suicide			

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

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

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
High blood pressure				Hay fever				Jaundice or hepatitis				Kidney stones			
Rheumatic fever				Allergy injection therapy				Rectal disease				Protein or blood in urine			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Hearing loss			
Pain or pressure in chest				Concussion				Hernia				Sinusitis			
Shortness of breath				Frequent or severe headache				Easy fatigability				Severe menstrual cramps			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Irregular periods			
Pneumonia				Severe head injury				Eye trouble besides need glasses				Sexually transmitted			
Chronic cough				Paralysis				Bone, joint, or other deformity				Blood transfusion			
Head or neck radiation treatments				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				Drug use			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Smoke 1+ pack cigarettes/week			
Diabetes				Pilonidal cyst				Broken bone (specify)				Regularly exercise			
Serious skin disease				Frequent vomiting				Kidney infection				Wear seat belt			
Mononucleosis				Gall bladder trouble or gallstones				Bladder infection				Color Blindness			

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.

Name _____	Use _____	Dosage _____	Name _____	Use _____	Dosage _____
Name _____	Use _____	Dosage _____	Name _____	Use _____	Dosage _____
Name _____	Use _____	Dosage _____	Name _____	Use _____	Dosage _____
Name _____	Use _____	Dosage _____	Name _____	Use _____	Dosage _____

**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 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 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 (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.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian, if student under age 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.**

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (Be certain that your name date of birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. **Keep a copy for your records.**)

- 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 transfer automatically. 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.**

➔ **COMPLETE INFORMATION BELOW - THEN DOCUMENT ON NEXT PAGE.**

<b>SECTION A:</b>	<b>IMMUNIZATION REQUIREMENTS ACCORDING TO AGE</b> (See footnotes for explanations in each immunization) NA=Not Applicable				
<b>STUDENTS 17 YEARS OF AGE AND YOUNGER</b>					
DTP or Td <sup>1</sup> 3	Polio 3	Measles <sup>2</sup> 2	Mumps <sup>4</sup> 1	Rubella <sup>4</sup> 1	
<b>STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER</b>					
DTP or Td <sup>1</sup> 3	Polio NA	Measles <sup>2,3</sup> 2	Mumps <sup>4</sup> 1	Rubella <sup>4</sup> 1	
<b>STUDENTS BORN BEFORE 1957</b>					
DTP or Td <sup>1</sup> 3	Polio NA	Measles NA	Mumps NA	Rubella <sup>4</sup> 1	
<b>STUDENTS 50 YEARS OF AGE AND OLDER</b>					
DTP or Td <sup>1</sup> 3	Polio NA	Measles NA	Mumps NA	Rubella NA	
<b>INTERNATIONAL STUDENTS</b>					
<b>Vaccine Required</b>					
Vaccines are required according to age (refer to appropriate box). Additionally, International students are required to have a TB skin test and negative result within the 12 months preceding the first day of classes (chest x-ray required if test is positive).					

**FOOTNOTES:**

1. DTP (Diphtheria, Tetanus, Pertussis), Td (Tetanus, Diphtheria): One Td booster within the last ten years
2. 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. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.
3. Two measles doses if entering college for the first time after July 1, 1994.
4. One dose on or after 12 months of age. Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

<b>SECTION B:</b>	These vaccines are <b>RECOMMENDED</b> . Some may be required by certain departments. Consult your college or department for specific requirements.
-----------------------	--

North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Attached to this form is information regarding meningococcal disease, including recommendations from the Centers for Disease Control of the U.S. Public Health Service. Please record on page 6 of this form, whether or not you have received the meningococcal vaccine. If **yes**, please note the month, day, and year of the vaccination.

<b>IMMUNIZATION RECORD</b>		(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 #
<b>SECTION A REQUIRED IMMUNIZATIONS</b>				
	mo./day/year (#1)	mo./day/year (#2)	mo./day/year (#3)	mo./day/year (#4)
• DTP or Td				
• Td booster				
• Polio				
• MMR (after first birthday)				
• MR (after first birthday)				
• Measles (after first birthday)			**Disease Date	****Titer Date & Result
• Mumps			***Disease Date NOT Accepted)	****Titer Date & Result
• Rubella			***Disease Date NOT Accepted)	****Titer Date & Result

<b>SECTION B REQUIRED IMMUNIZATIONS</b>				
The following immunizations are required for all students. Any exceptions are indicated below.				
<ul style="list-style-type: none"> <li>• Hepatitis B series only</li> </ul> <p style="text-align: center;"><b>OR</b></p> <ul style="list-style-type: none"> <li>• Hepatitis A/B combination series</li> </ul> <p style="text-align: center;"><b>OR</b></p> <ul style="list-style-type: none"> <li>• Sign a Declination - IF ALLOWABLE (available from program director)</li> </ul>	mo./day/year	mo./day/year	mo./day/year	****Titer Date & Result
<ul style="list-style-type: none"> <li>• Varicella (chicken pox) series of two doses or immunity by positive blood titer –</li> </ul> <p><b>REQUIRED FOR:</b></p> <ul style="list-style-type: none"> <li>• AD Nursing</li> <li>• MLT</li> <li>• PBT</li> <li>• PTA</li> <li>• Respiratory Therapy</li> <li>• SON</li> </ul> <p><b>RECOMMENDED FOR:</b></p> <ul style="list-style-type: none"> <li>• EMS</li> <li>• HIT</li> <li>• PNE</li> <li>• RAD</li> </ul>			Disease Date	****Titer Date & Result
<ul style="list-style-type: none"> <li>• Tuberculin (PPD) Test (within 12 months) Date read mm induration</li> </ul>				
<ul style="list-style-type: none"> <li>• Chest x-ray, if positive PPD Date Results</li> </ul>				
<ul style="list-style-type: none"> <li>• Treatment if applicable Date</li> </ul>				

**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

\*\* Must repeat Rubeola (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 immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

\*\*\*\* Attach Lab report

**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 Name	Date of Birth (mo/day/year)	Social Security Number
-----------	------------	-------------	-----------------------------	------------------------

Permanent Address	City	State	Zip Code	Area Code/Phone Number
-------------------	------	-------	----------	------------------------

Height \_\_\_\_\_ Weight \_\_\_\_\_ TPR \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

<p><b>REQUIRED:</b></p> <p><u>Vision:</u> Corrected Right 20/ _____ Left 20/ _____                  Uncorrected Right 20/ _____ Left 20/ _____                  Color Vision _____</p> <p><u>Hearing:</u> (gross) Right _____ Left _____                  15 ft. Right _____ Left _____</p>	<p><b>NOT REQUIRED – Unless Recommended by Physician:</b></p> <p><u>Urinalysis:</u> Sugar: _____ Albumin _____                  Micro _____</p> <p><u>Hgb</u> or <u>Hct</u> (if indicated) _____</p> <p><u>STS</u> (may be required by some departments)                  Date _____ Results _____</p> <p>Recommendations _____</p>
---	---

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 \_\_\_\_\_

<p>• Only for Students Admitted to a <b>HEALTH SCIENCES PROGRAM</b> •</p>
Based on my assessment of this student's physical and emotional health on _____, he/she appears able to participate in the activities of a health profession in a clinical setting. Yes _____ No _____ if no, please explain _____ (Date)

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 \_\_\_\_\_