Jerry Sutton Public Safety Training Center
225 Industrial Park Loop
Franklin, NC 28734
(828) 306-7045 □ Fax (828) 369-2428
www.southwesterncc.edu/content/public-safety-training

Southwestern Community College
Extension Education Fire & Rescue Training Programs
Student Medical Form

This medical form is designed to help insure the health and well-being of our students as well as that of their patients and clients.

- The entire medical form (immunization record, report of medical history, family and personal health history, and physical examination) is required for all students.

- In the physical exam section please note that all areas are required except the boxed item identified as not required unless recommended by physician.

- This form must be completed and returned to the Fire and Rescue Program Coordinator on the first class meeting in order to enroll in the course.

- Any questions concerning this form should be addressed to the Fire and Rescue Program Coordinator.

SCC - PSTC

FIRE / RESCUE TRAINING PROGRAM

MEDICAL EXAMINATION REPORT

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT

BE RELEASED TO UNAUTHORIZED PERSONS.

Jerry Sutton Public Safety Training Center

225 Industrial Park Loop

Franklin NC 28734

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.)_____

SCCPROGRAM_____

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

NAME OF POLICY HOLDER SOCIAL SECURITY NUMBER EMPLOYER

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

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 the 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 have you now: (please check at right of each item and if answered *yes*. indicate 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 inection therapy			
Arthritis			
Concussion			
Frequent or severe headache			
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			
Enema or Sickle Cell anemia			
Eye trouble besides Reading glasses			
Bone, joint. or other betormitv			
Knee problems			
Recurrent back pain			
neck injury			
back injury			
broken bone			
kidney infection			
bladder infection			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack of cigarettes per			
Regularly exercise			
Wear seat belt			
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 inkjet 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 explain type of reaction, your age when the reaction occurred, and if the reaction 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.

SECTION A: IMMUNIZATION REQUIREMENTS ACCORDING TO AGE (SEE footnotes for explanations in each immunization) NA=Not Applicable

STUDENTS 17 YEARS OF AGE AND YOUNGER

DTP or Td[1]	Polio	Measles[2]	Mumps[4]	Rubella[4]
3	3	2	1	1

STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER

DTP or Td[1]	Polio	Measles[2 3]	Mumps[4]	Rubella[4]
3	NA	2	1	1

STUDENTS BORN BEFORE 1957

DTP or Td[1]	Polo	Measles	Mumps	Rubella[4]
3	NA		NA	1

STUDENTS 50 YEARS OF AGE

DTP or Td[1]	Polio	Measles	Mumps	Rubella
3	NA	NA	NA	NA

INTERNATIONAL STUDENTS

Vaccine Required

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 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.
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.

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 #

SECTION A REQUIRED IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
• DTP or Td	(#1)	(#2)	(#3)	(#4)
• 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

SECTION B REQUIRED IMMUNIZATIONS
The following immunizations are required for all students. Any exceptions

	mo./day/year	mo./day/year	mo./day/year	
• Hepatitis B series only OR • Hepatitis A/B combination series OR • Sign a Declination - IF ALLOWABLE (available from program director)				****Titer Date & Result
• Varicella (chicken pox) series of two doses or immunity by positive blood titer-			Disease Date NOT Accepted	****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				

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 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 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.

This section is 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 _____ ' _____

REQUIRED:	NOT REQUIRED – Unless Recommended by Physician:
Vision: Corrected Right 20/ _____ Left 20/ Uncorrected Right 20/ _____ Left 20/ Color Vision _____ Hearing: (gross) Right ____ Left _____ 15ft Right____ Left_____	Urinalysis: Sugar:___ Albumin _____ Micro---------- Hab or Hct if indicated _ _ _ _ _ _ _ _ _ STS (may be required by some departments) Date _____ Results ____ Recommendations

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 _____

Based on my assessment of this student's physical and emotional health on _____, he/she appears to be able to participate
(Date)
In the activities of a health profession in a clinical setting and participate in a moderate physical exercise program. 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