

Vermont State Colleges Health Form

Castleton State College, 248 South Street, Castleton, VT 05735
Johnson State College, 337 College Hill, Johnson, VT 05696
Lyndon State College, 1001 College Road, 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 _____

Health Insurance Company:

Student ID # _____

Birth Date _____

Policy # _____

Program of Study _____

Person to Notify In Case of Emergency:

Permanent Address:

Name _____

Relationship _____

Address _____

Home Phone # _____

Cell Phone # _____

Home Phone # _____

Work Phone # _____

Cell Phone # _____

NO HEALTH INSURANCE? Check here _____

Work Phone # _____

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.

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)

Medical History

(To Be Completed By Student)

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.)

Hospitalizations: No Yes Have you ever been hospitalized for any surgical or medical or psychiatric illness? (If yes, specify diagnosis and date) _____

Have you received counseling or psychiatric care within the last six years? No Yes (**Specify in comments**)

Do You Have or Previously Had the Following (check those that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> asthma
<input type="checkbox"/> attention deficit disorder
<input type="checkbox"/> back problems
<input type="checkbox"/> bleeding disorder
<input type="checkbox"/> blood transfusion
<input type="checkbox"/> breast pain or abnormality
<input type="checkbox"/> broken bone
<input type="checkbox"/> cancer
<input type="checkbox"/> chickenpox
<input type="checkbox"/> cholera
<input type="checkbox"/> concussion/head injury
<input type="checkbox"/> counseling help
<input type="checkbox"/> diabetes
<input type="checkbox"/> eye problems
<input type="checkbox"/> eating disorder | <input type="checkbox"/> frequent ear infections
<input type="checkbox"/> fainting
<input type="checkbox"/> frequent/migraine headaches
<input type="checkbox"/> hearing loss
<input type="checkbox"/> heart murmur
<input type="checkbox"/> heart problem
<input type="checkbox"/> hepatitis/liver disease
<input type="checkbox"/> hernia
<input type="checkbox"/> high blood pressure
<input type="checkbox"/> high cholesterol
<input type="checkbox"/> joint or limb problem
<input type="checkbox"/> kidney/bladder problems
<input type="checkbox"/> malaria/yellow fever
<input type="checkbox"/> menstrual problems/abnormal pap
<input type="checkbox"/> mental health issues
<p style="text-align: center;">(anxiety, depression, other)</p> | <input type="checkbox"/> mononucleosis
<input type="checkbox"/> overweight
<input type="checkbox"/> pneumonia
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> rheumatic fever
<input type="checkbox"/> scoliosis
<input type="checkbox"/> seizure
<input type="checkbox"/> skin problems(acne, etc)
<input type="checkbox"/> stomach or bowel problems
<input type="checkbox"/> thyroid disease or disorder
<input type="checkbox"/> tuberculosis
<input type="checkbox"/> underweight
<input type="checkbox"/> urinary tract infection
<input type="checkbox"/> use tobacco/other substances
<input type="checkbox"/> consume alcohol |
|--|--|---|

Comments _____

Family History [siblings, parents, grandparents] (check those that apply):

- | | |
|--|---|
| <input type="checkbox"/> alcoholism
<input type="checkbox"/> bleeding disorder
<input type="checkbox"/> cancer
<input type="checkbox"/> depression/anxiety/mental health disease
<input type="checkbox"/> diabetes | <input type="checkbox"/> heart attack or stroke
<input type="checkbox"/> high blood pressure
<input type="checkbox"/> high cholesterol
<input type="checkbox"/> migraine headaches
<input type="checkbox"/> thyroid disease |
|--|---|

Comments _____

Student Signature _____ Date ___/___/___

Signature of Person Completing Form _____ Date ___/___/___
 (if other than student)

Reviewed by Health Care Provider Yes Date ___/___/___

Physical Exam

(To Be Completed By Health Care Provider)

Name of Student _____ Date of Birth ___/___/___ Date of Exam ___/___/___
Last First MI (within past 12 months)

Height _____ Weight _____ BP _____ Pulse _____

Vision Uncorrected: R _____ L _____ 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

Is the student receiving medical care for a chronic condition or serious illness? No Yes
 (if yes, comment below)

Do you have any concerns about the student participating in competitive physical activity? No Yes
 (if yes, comment below)

Do you feel that there are any mental or emotional concerns to be aware of? No Yes
 (if yes, comment below)

Comments:

Provider Signature _____ Date ___/___/___

Immunizations

(To Be Completed By Health Care Provider)

This form must be completed and signed by a health care provider. **Vermont State Law requires proof of the following vaccinations OR documented disease OR a positive titer. You may not register for classes until the completed Health Form and immunization information is received by the college Health Center.**

Required Immunizations:

MMR (Measles, Mumps, Rubella): Date #1 ___/___/___ Date #2 ___/___/___ OR

Measles Titer: Date ___/___/___ Mumps Titer: Date ___/___/___ Rubella Titer: Date ___/___/___
(attach copy of lab reports)

Td (tetanus/diphtheria) Date ___/___/___ OR Tdap (tetanus/diphtheria/pertussis) Date ___/___/___

Hepatitis B Series Dates #1 ___/___/___ #2 ___/___/___ #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 ___/___/___

*Rabies Vaccine Series (for Vet Tech Students) Dates #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Polio Vaccine Series (for all Nursing Students) Dates #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ Or

Polio Titer: Date ___/___/___ (attach copy of all lab reports)

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, kidney disease, 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 ___/___/___

Provider Printed Name
Address, Phone and Fax #

*recommended

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