YORK TECHNICAL COLLEGE

452 S. Anderson Road, Rock Hill, SC 29730
HEALTH AND HUMAN SERVICES DIVISION
STUDENT HEALTH FORM
(Revised and Approved October 2013)

The health form must be completed within three (3) months prior to the program entry date and returned to the Health and Human Services Division, York Technical College, 452 S. Anderson Road, Rock Hill, SC 29730. **The student should complete pages 1 & 2, and a licensed physician or Certified Nurse Practitioner should complete pages 3-7.**

Date _____

Student Name _____ Program _____

Address _____

_____
City State Zip

Date of Birth _____ Social Security # _____

Telephone No. _____
Home Business

IN CASE OF EMERGENCY, NOTIFY:

Name _____ Relationship _____ Telephone # _____

Alternate _____ Relationship _____ Telephone # _____

Family Physician _____ Telephone # _____

IF STUDENT IS UNDER AGE 18, PARENT/GUARDIAN MUST SIGN:

IN CASE OF MEDICAL EMERGENCY, I understand every effort will be made to contact the parent or guardian of the student. In the event I cannot be reached, I hereby give permission to the physician selected by the TECH administration to hospitalize, secure proper treatment, and to order injection, anesthesia or surgery for my child, as named above.

Signature _____ Date _____

STUDENT CERTIFICATION STATEMENT

- I hereby certify that all information on this form is correct.
- I will immediately report any change in my health status to the Department Chair of my program.
- I understand that I am subject to alcohol and/or drug testing at random (by clinical site) or for reasonable suspicion (by clinical site or York Technical College) while enrolled in this program.

Student's Signature _____ Date _____

Student Name_____

PHYSICAL ASSESSMENT
SECTION A - GENERAL INFORMATION
(The student should complete Section A.)

1. Current medications: _____

2. Known allergies: _____

3.Have you ever had any episodes of unconsciousness or convulsive seizures:_____ If yes, please specify: _____

4. Have you ever had or been recommended/referred for psychiatric, psychological and/or substance abuse treatment or counseling? _____

If yes, please specify _____

5. Do you currently have any infectious disease? _____

If yes, please specify _____

6. Have you ever been treated or has treatment been recommended for any of the following?

	YES	NO		YES	NO
Arthritis			Hepatitis		
Back Injury			High Blood Pressure		
Broken Bones			Kidney Disease		
Diabetes			Polio		
Eczema			Rheumatic Fever		
Epilepsy/Seizures			Thyroid Disease		
Fainting Spells			Tuberculosis		
Headaches			Ulcers		
Hearing Loss			Vision Loss		
Heart Disease			Weight Loss or Gain		

If you answered yes to any of the above, please explain. _____

_____

_____

_____

Student Name:_____

VERIFICATION OF REQUIRED IMMUNIZATIONS
SECTION B
(A licensed physician or Certified Nurse Practitioner should complete Section B.)

A. MMR –**Proof of 2 vaccinations AND Rubella titer required**

Immunity status is defined below. Please complete either **section 1 OR section 2:**

1- Date of live mumps vaccine on or after the first birthday Date 1st _____
AND
Receipt of second dose of MMR vaccine Date 2nd _____

AND Rubella titer **Titer Date and Results**_____

OR if no proof of MMR vaccinations is available, you must have MMR titers for Measles, Mumps and Rubella.

2- MMR titer results Titer Date _____

Titer Results

Mumps _____

Rubeola Measles _____

Rubella (German Measles) _____

B. Chickenpox (**Varicella titer required**)

1- Laboratory evidence of chickenpox immunity Results _____
(Varicella titer) Date _____

Student Name _____

E. Diphtheria-Tetanus Booster
Please document the date of your last diphtheria-tetanus booster. **The last booster must have been received in the past ten (10) years.**

1- Date of diphtheria-tetanus booster _____

F. Hepatitis B Vaccination Please complete **ONE** of the following:
The Hepatitis B vaccine can be taken to prevent the transmission of Hepatitis B. The series of three (3) injections is recommended by OSHA for all health care workers. Students in Health & Human Services Programs who decline this vaccine must document their decision on a declination form upon entry into the program of choice.

1. Hepatitis B Series

First injection Date _____
Second injection Date _____
Third injection Date _____

2. Hepatitis B Antibody Titer (**required only if dates of vaccination not available**) Result _____
Date _____

G. Tuberculosis Screening
Students in a Health & Human Services Program must be screened for tuberculosis within 3 months prior to entering their program of choice and yearly while in the program. The 2-Step PPD is required for all first time PPD's. **Test dates must be at least one week apart and no more than 3 months apart.**

1- **Mantoux PPD Skin Test**

#1Site placed_____ anterior forearm (Enter Lt or Rt)

#1 Date placed _____Lot # _____Date read _____Results **in MM of induration** _____(Neg/Pos)

#2 Site placed_____ anterior forearm (Enter Lt or Rt)

#2 Date placed _____Lot # _____Date read _____Results **in MM of induration** _____(Neg/Pos)

(Tine tests are not acceptable)

2- Chest X-Ray (If PPD skin test is positive.)*
Results
Date_____

*Persons who have a history of a positive PPD skin test reaction must provide evidence of evaluation and/or treatment of the positive skin test by the local Health Department in addition to the most recent chest x-ray repeat. Documentation must accompany this form.

Persons who have had treatment for tuberculosis must provide physician or clinic documentation of the nature and duration of the treatment in addition to the results of the most recent chest x-ray.

Student Name _____

PHYSICIAN'S EVALUATION
SECTION C
(A licensed physician or Certified Nurse Practitioner should complete Section C.)

Height _____ Weight _ BP _____

Pulse _____ Hemoglobin. _____

Urinalysis: Glucose_____
Albumin _____

Allergies: (Please specify)

	CORRECTED	
	YES	NO
Eyes		
Ears		
Nose		
Throat		
Mouth/Teeth		
Neck		
Breast		
Lungs		
Cardiovascular		
Abdomen		
Hernia		
Nervous System		
Skin		
Orthopedic		
Psychiatric		
Other (Physical disabilities, etc.)		

List any medical problems the student has had in the past.

Student Name_____

Is the student currently receiving medication or treatment for any disease or condition? _____
If yes, please explain:

Section C continued.

Please provide any additional pertinent information concerning this student's potential participation in patient care in a clinical setting (include chronic illnesses or infectious diseases).

Do you consider this student physically qualified for college classes and clinical rotations? Yes ____ No _____

Do you consider this student emotionally qualified for college classes and clinical rotations? Yes ____ No _____

Recommendations or Restrictions (Diet, Medication, Physical Activity):

Comments:

Student Name _____

Physician's or Certified Nurse Practitioner's Name (Print) _____

Signature _____

Address _____

Phone # _____

Date _____