

# 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**

**#1** Site 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 \_\_\_\_\_