Thaddeus Stevens College of Technology

Student Health and Counseling
750 E. King Street - Brenner Hall - Lancaster, PA 17602
717-299-7769 – meshey@stevenscollege.edu
717-391-3561 (fax)

MEDICAL RECORDS

Last Name | First Name | Middle Initial | Date of Birth

Home Address | City | State | Zip | Home Phone Number

Social Security Number | email address

Biological Sex □ Male □ Female Gender Identity_____

IN CASE OF EMERGENCY, NOTIFY:

Name | Relationship

Home Address | City | State | Zip | Home Phone Number

Work Address | City | State | Zip | Work Phone Number

HISTORY

Acne	□ Current	□ Past	□ Never	Gallbladder D/O	□ Current	□ Past	□ Never
ADD/ADHD	□ Current	□ Past	□ Never	Gonorrhea	□ Current	□ Past	□ Never
AIDS, ARC, + HIV	□ Current	□ Past	□ Never	Gout	□ Current	□ Past	□ Never
Alcohol Problem	□ Current	□ Past	□ Never	Hay Fever	□ Current	□ Past	□ Never
Allergies	□ Current	□ Past	□ Never	Knee Injury	□ Current	□ Past	□ Never
Anemia	□ Current	□ Past	□ Never	Hearing Loss	□ Current	□ Past	□ Never
Anxiety D/O	□ Current	□ Past	□ Never	Heart Problems	□ Current	□ Past	□ Never
Asthma	□ Current	□ Past	□ Never	Specify_____			
Back Problems	□ Current	□ Past	□ Never	Heart Murmur	□ Current	□ Past	□ Never
Bladder Infection	□ Current	□ Past	□ Never	Hepatitis	□ Current	□ Past	□ Never
Bleeding trait/	□ Current	□ Past	□ Never	Herpes	□ Current	□ Past	□ Never
sickle cell				Hypertension	□ Current	□ Past	□ Never
Bronchitis	□ Current	□ Past	□ Never	Hypoglycemia (low blood sugar)	□ Current	□ Past	□ Never
Cancer (location)	□ Current	□ Past	□ Never	Infectious Mononucleosis	□ Current	□ Past	□ Never
_____				Irritable Bowel Disease	□ Current	□ Past	□ Never
Chlamydia	□ Current	□ Past	□ Never	Kidney Infections/stones	□ Current	□ Past	□ Never
Colitis	□ Current	□ Past	□ Never	Knee Injury	□ Current	□ Past	□ Never
Concussion	□ Current	□ Past	□ Never	Learning Disability	□ Current	□ Past	□ Never
Depression	□ Current	□ Past	□ Never	Migraine H/a, Vascular H/a	□ Current	□ Past	□ Never
Diabetes	□ Current	□ Past	□ Never	Obesity (more than 20lbs overweight)	□ Current	□ Past	□ Never
Drug Dependent	□ Current	□ Past	□ Never	Ovarian Cyst	□ Current	□ Past	□ Never
Eating D/o	□ Current	□ Past	□ Never	Peptic Ulcer	□ Current	□ Past	□ Never
Eczema	□ Current	□ Past	□ Never	Phlebitis	□ Current	□ Past	□ Never
Emotional/	□ Current	□ Past	□ Never	Pneumonia	□ Current	□ Past	□ Never
mental illness				Rheumatic Fever	□ Current	□ Past	□ Never
Epilepsy/seizures	□ Current	□ Past	□ Never	Rheumatoid Arthritis	□ Current	□ Past	□ Never
Eye Problem	□ Current	□ Past	□ Never	Sinus Problem (Chronic)	□ Current	□ Past	□ Never
Specify_____				Suicide Attempt	□ Current	□ Past	□ Never
Fainting	□ Current	□ Past	□ Never	Syphilis	□ Current	□ Past	□ Never
Specify_____				Thyroid Problem	□ Current	□ Past	□ Never

Tension h/a □ Current □ Past □ Never
Tuberculosis □ Current □ Past □ Never
Varicella □Current □ Past □ Never

Other Problems not listed (specify)
_____

Injuries, surgeries, and hospitalizations:_____
_____
_____

Dietary Needs:_____
_____

Smoking Status: □ Yes □ No # packs per day_____

Have you traveled outside the U.S. in the past year? □ Yes □ No
Where?_____

Mental Health History:

Have you ever received psychiatric counseling □ Yes □ No □ Currently
Have you ever been hospitalized for psychiatric care? □ Yes □ No
Have you ever been treated for an eating d/o? □ Yes □ No
Have you ever been treated for alcohol or drug dependency? □ Yes □ No

List all current prescription medications:

Medication Name	Prescribing Provider	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies? □ Yes □ No

If "yes" please list:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you received allergy shots? □ Yes □ No

Family History

	Age	Status of Health	Occupation	If deceased, age & cause of death
Mother				
Father				
Siblings				

Are you adopted? □ Yes □ No

You are invited to discuss your answers or any other health related issues with the Student Health Services professional staff.

The information that I have provided on this health form is accurate, to the best of my knowledge. I understand that all information is maintained as confidential within Student Health Services.

Applicants Signature **Date**

PHYSICAL EXAM

To be completed by Physician:

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_____

Last Name First Name Middle Initial

BP_____Heart Rate_____Height (in.)_____Weight (lbs)_____

Examination Findings (Describe fully. Use additional sheets if necessary)

	NL	ABN	Findings (describe)		NL	ABN	Findings (describe)
General Appearance	□	□	_____	Neck	□	□	_____
Skin	□	□	_____	Chest	□	□	_____
Head	□	□	_____	Heart	□	□	_____
Eyes	□	□	_____	Abdomen	□	□	_____
Nose/Sinus	□	□	_____	Extremities	□	□	_____
Mouth	□	□	_____	Neuro	□	□	_____

General Comments_____

_____

_____

Recommendations for physical activity:

Including physical education, athletic activities, sports, **essential skills r/t program of study**): □ Unlimited □ Limited

Explain_____

_____

Is the patient now under treatment for any medical or emotional condition? □ Yes □ No

Explain_____

_____

_____

Practitioner's signature Phone Number

_____

Print Last Name Date

_____

Address City State Zip

AUTHORIZATION FOR TREATMENT OF MINORS

If the student has not yet reached her/his 18th birthday before the beginning of the academic year for which the student is registered, the following authorization by a parent or legal guardian is required.

I hereby grant permission to TSCT to proceed with any needed medical, mental health, or minor injuries treatment for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the medical provider to contact me in the most expeditious manner possible. If said provider is unable to communicate with me, the treatment necessary for the best interest of the above named student will be given.

Signature:_____ **Date**_____

Printed Name:_____ **Relationship to student**_____

Home Phone Number:_____ **Work Phone Number:**_____

STUDENT IMMUNIZATION RECORD

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_____
Last Name First Name Middle Initial

_____ **M F**
Date of Birth Biological sex (circle)

MANDATORY IMMUNIZATIONS for Thaddeus Stevens College of Technology

To be completed and signed by a health care provider. (Dates must include month, day & year)

REQUIRED IMMUNIZATIONS:

M.M.R (Measles, Mumps, Rubella) **OR** **M.M.R. Titer** (Measles, Mumps, Rubella

Option 1
Dose 1 – Immunized at 1 yr or after
_____/_____/_____

Dose 2 – At least 4 weeks after dose 1
_____/_____/_____

Option 2
Lab Report of titer_____
Copy of report must be attached

Tetanus – Diphtheria (TD booster within last 10 years)
TD _____/_____/_____
Or
Tdap _____/_____/_____

Meningococcal Vaccine Information

For individuals 18 years or older:
I am 18 years of age or older, I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of the meningococcal vaccine. I understand that meningococcal disease is rare but life-threatening illness. I understand that Pennsylvania law requires an individual enrolled in an institution of higher education in Pennsylvania who resides on campus in student housing to receive vaccination against meningococcal disease unless the individual signs a waiver.

Meningococcal Waiver
I choose to waive the meningococcal vaccine.

_____
Signature of student (parent if under 18)

Date _____/_____/_____

If vaccine has not been received, a meningococcal waiver must be signed by student/parent

or

Meningococcal Vaccine
MCV(Menactra/Menveo/Menomune)

Date _____/_____/_____

Booster
(if initial dose was given before 16th birthday)
Date _____/_____/_____

Bexsero/Trumenba (type B)

Date _____/_____/_____

RECOMMENDED IMMUNIZATIONS:

Hepatitis B
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____
Dose 3 _____/_____/_____

Varicella
History of Disease (year)_____
or
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____

Other:_____
_____

Practitioner's Signature:_____ **Print last name:**_____**Date:**_____
Address:_____**City:**_____**State:**_____**Zip:**_____**Phone #**_____

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_____

Student Name

_____

Date of Birth

HEALTH INSURANE COMPANY

Name

Policy Holder

Policy No. Group No.

Insurance company address City State Zip

Insurance company phone number

Copy of insurance card must be attached.

Dear Physician,

Each major at Thaddeus Stevens College of Technology has a significant lab component that replicates actual duties required in the workplace. Please review the following physical skills that are essential to these majors. Place circle any skill which the student may have difficulty performing. If the skill may be accommodated, provide a letter documenting how you recommend the skill be accommodated. The recommendation will be reviewed by the college. **Please sign the form to indicate that it was reviewed.**

Thank you for aiding in providing a safe working environment for our students.

Safety Sensitive Majors

Building: **Cabinet making, Carpentry, Electrical, Electro-Mechanical, Masonry, Plumbing, Residential Remodeling, Career Prep class**

Bending/Twisting	Crawling	Coordination
Lifting	Reaching	Climbing
Working outdoors	Working in cramped spaces	Balance
Exposure to Dust	Exposure to chemicals	Exposure to extreme temperatures
Eye Hand Coordination	Manual Dexterity	Finger Dexterity
Visual Discrimination	Near vision	Far Vision
Color Discrimination	Depth Perception	Repetitive Movements
Operating Power tools	Grasping	

Automotive: **Collision Repair, Automotive**

Exposure to dust	Exposure to chemicals	Grasping
Bending	Twisting	Depth perception
Crawling	Lifting	Near vision
Near vision	Color Discrimination	Hearing Sensitivity
Speech Recognition	Finger Dexterity	Manual Dexterity
Eye Hand coordination		

Metals/Machining: **Machine, Metals Fabrication and Welding**

Standing for extended time	Using Hazardous Equipment	
Reaching	Lifting	Grasping
Finger Dexterity	Manual Dexterity	Eye Hand coordination
Visual Discrimination	Near vision	
Repetitive movements involving fingers, hands, arms		

Heating, Ventilation & Air Conditioning/Water Environmental Technology

Walking	Bending	Twisting
Crawling	Lifting	Working in tight spaces
Exposure to chemicals	Exposure to extreme temperatures	
Work outdoors	Near Vision	Far Vision
Visual Discrimination	Color Discrimination	Speech Recognition
Depth Perception	Hearing Sensitivity	

<u>Computer based majors</u>: **Architecture, Business Administration, Computer Aided Technology, Computer Networking, Electronics, Graphic Communications, and Mechanical Engineering**

Sitting for extended time	Repetitive movements involving fingers, hands	
Grasping	Manual Dexterity	Finger Dexterity
Eye hand coordination	Visual Discrimination	Near Vision
Far Vision	Color Discrimination	Depth Perception
Speech Recognition	Speech Clarity	

My signature below indicates that these skills were reviewed and the student at this time appears able to perform the skills necessary for his/her program of study.

_____ _____

Physician Signature **Date**