COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORD

PLEASE PRINT

Name: _____ SS#: _____
(Last) (First)

Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Phone: _____
(mo/dy/yr)

Technology: _____ Quarter to Begin: _____

IMMUNIZATION AND TESTING

1. PPD by Mantoux (tuberculin testing) is required within the past year. You can obtain the Tb test at your physician's office.

   Date given: _____ Date read: _____ Results: _____/_____ mm

   [If CXR, date: _____ Results: _____ Meds: _____]

2. Hepatitis B Vaccine Series is required. Provide documentation from your physician, health care provider, or employer.

   Date of Hep B#1: _____ Hep B#2: _____ Hep B#3: _____

HEALTH HISTORY

1. Please list any serious medical problems, injuries, or surgical procedures you have had.

   _____

   _____

2. Do any of the items listed above require continuing physician's evaluation or treatment? Please describe.

   _____

   _____

3. List all medications you are taking.

   _____

4. Do you have a sensitivity or allergy to latex? If yes, describe response: _____

   _____

5. List all allergies: _____

6. Do you have any limitations or restrictions in the following area? Please describe.

   a. Lifting up to 60 pounds?

   _____

   b. Reaching, handling, feeling, manual dexterity?

   _____

   c. Speaking and hearing, as in a classroom, or when using a stethoscope?

   _____

   d. Seeing clearly, as in reading thermometers or gauges?

   _____

   e. Standing and sitting equally for two hours at a time?

   _____

It is the policy of Columbus State Community College not to discriminate against any individual or groups of individuals in the College's programs or policies. This assurance of non-discrimination shall include applicants for employment or academic admission, students, and employees, and shall be applied regardless of race, color, gender, age, religion, ancestry, national origin, disability, or veteran status.

I certify that no information regarding my health history has willfully been omitted and that to the best of my knowledge, recollection, and belief, the information I have given on this record is an accurate and complete account of my health history. I understand that providing false information on this document is a serious offense which will result in disciplinary action. I understand that if my health, physical condition, or physical abilities change in any way (e.g. surgery, pregnancy, injury, new medical diagnoses) during the course of my studies at Columbus State, I must report these changes in my health to the College Health Office. I understand that immunization records, titer results, and tuberculin testing information may be released to hospitals or other health facilities upon their request, prior and pursuant to my affiliation with them. I understand that conditions which may affect my ability to perform essential functions of the clinical tasks, or which may affect my ability to function with safety for myself and/or others might be discussed with my department chair or program coordinator.

_____ _____

(Date) **(Student Signature)**

WAIVER FOR HEPATITIS B IMMUNIZATION

NAME: _____

SS#: _____

I understand that due to my educational or occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I also understand or have had explained to me that Hepatitis B is a very serious infection of the liver which can cause me significant illness or death. I understand that if I become infected with Hepatitis B, I can infect others through blood-to-blood contact or through sexual contact. I understand that the Hepatitis B immunization could protect me from the Hepatitis B infection.

Despite knowing this, I request a waver from the Hepatitis B immunization requirement. In choosing not to receive the Hepatitis B immunization, I understand that I continue to be at risk of acquiring Hepatitis B infection. Should I become infected with Hepatitis B during my studies or employment, I will not hold Columbus State Community College or any of its associates or affiliates liable for any consequences in perpetuity.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

TECHNOLOGY/DEPARTMENT: _____

WITNESS: _____