



**HOUSING AND RESIDENCE LIFE HEALTH FORM**

**PART I – REPORT OF MEDICAL HISTORY**

Please complete *(print all sections)*. **International students: please provide all health documents translated into English.**

<b>Student Name:</b> _____ <small style="margin-left: 100px;">Last</small> <small style="margin-left: 100px;">First</small> <small style="margin-left: 100px;">Middle</small>	<b>Student ID #:</b> _____
<b>Home Address:</b> _____	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____
<b>City/State/Zip:</b> _____	<b>Preferred:</b> <input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them
<b>Home Phone:</b> _____	<b>Cell Phone:</b> _____
<b>Email Address:</b> _____	<b>Date of Birth:</b> _____
<b>Program/Major:</b> _____	<b>On Campus Housing:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Semester:</b> <input type="checkbox"/> FA <input type="checkbox"/> SP <input type="checkbox"/> SU    Year _____	<b>Campus:</b> <input type="checkbox"/> Main <input type="checkbox"/> Fowler <input type="checkbox"/> Monroe

**I. EMERGENCY NOTIFICATION**

<b>Name of Contact:</b> _____ <b>Address:</b> _____ <b>Phone:</b> _____	<b>Relationship:</b> _____  <b>Alternate Phone:</b> _____
---	---

**II. MEDICAL HISTORY** – Please answer yes or no to all questions and insert the year for all positive answers:

	Yes	No	Please Explain
Allergies			
Asthma			
Cardiac			
Chemical Dependency			
▪ Drugs			
▪ Alcohol			
Diabetes Mellitus			
Gastrointestinal Disorder			
Hearing Disorder			
Hypertension			
Neuromuscular			
Orthopedic Condition			
Respiratory Illness			
Seizure Disorder			
Vision Disorder			
Other (Specify)			

**ACCIDENT AND HEALTH INSURANCE (Recommended)** – Student should upload a copy of current health insurance card (front and back) to myRecordTracker®. It is recommended that students have valid health insurance while using on-campus housing, and notify the Residence Hall Director and/or Health and Wellness Center of any change in health insurance which occurs during the academic year, and upload a copy of the new insurance card. If you choose not to provide this information, please upload a typed or handwritten paper stating that you do not wish to provide health insurance documentation.

*If the above named emergency contact cannot be reached at the time of an emergency, the College is authorized to send the above named student to the nearest hospital and/or to administer necessary emergency care. In addition, I authorize the release of information regarding my health/medical status to the Residence Hall Director and appropriate designee(s), to the Northampton Community College Health and Wellness Center, to the appropriate health care agency, and/or to the above named emergency contact.*

Student Signature (Parent/Guardian if under 18 years of age)	Date
--	------

## PART II-REPORT OF MEDICAL EXAMINATION

A physical examination completed **within 6 months of moving into the residence hall**, and every 2 years thereafter, by a licensed medical provider (MD, DO, CRNP, or PA-C) is **required**. Moving into the residence hall is **PROHIBITED** until the required medical forms are uploaded and verified.

Name: \_\_\_\_\_ Student ID: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last First Middle

I. Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

II. Vision Uncorrected R \_\_\_\_\_ L \_\_\_\_\_  
 Corrected R \_\_\_\_\_ L \_\_\_\_\_

III. Clinical Examination: *Describe details of abnormalities* Date of Examination: \_\_\_\_\_

	Normal	Abnormal	Comments
Skin			
Head and scalp			
Eyes			
Ears/Hearing			
Mouth, Nose, Throat			
Neck			
Heart			
Lungs			
Abdomen			
Genitourinary			
Musculoskeletal			
Neurological			
Psychiatric			
Exposure to Hepatitis A, B, or C			<i>If positive for exposure, please submit titers.</i>

Allergies	
Medications taken on a regular basis	

<b>**IMPORTANT** LICENSED PROVIDER, PLEASE INITIAL TO CERTIFY THE FOLLOWING:</b>	<b>INITIALS</b>
I certify that the above-named student is free from communicable diseases in the communicable state.	
I certify that the above-named student has no medical conditions or restrictions. (If the applicant has restrictions that require accommodation, please note them in the comments section below.)	
Comments ( <i>if applicant has any limitations, please explain</i> ):	

**Please print, type or stamp:**

Name of Licensed Provider \_\_\_\_\_

Address: \_\_\_\_\_

Phone \_\_\_\_\_

Signature of Licensed Provider \_\_\_\_\_ Date \_\_\_\_\_

## CLINICAL REQUIREMENTS

To meet the requirements set forth by NCC, Clinical Sites and OSHA, you will need to obtain and upload to myRecordTracker® documentation for the following immunizations and tests to reside in On-Campus housing.

### IMMUNIZATIONS (Required Vaccinations)

All students are required to UPLOAD **immunization records** to myRecordTracker® for the following:

- ♣ **Varicella** (Chickenpox) – 2 doses after age 12 months
- ♣ **MMR\*** – 1<sup>st</sup> dose after age 12 months, and 2<sup>nd</sup> dose after age 4 years
- ♣ **Hepatitis B** – 3 doses (*Recommended*)
- ♣ **Meningococcal A-C-W-Y** (*After Age 16, and within the past 5 years*)
- ♣ **TDAP** – Tetanus Diphtheria Acellular Pertussis (*Dated within 10 years*)

### IMMUNIZATIONS (Strongly Recommended)

It is **strongly recommended** that all students obtain and submit documentation for the following:

- ♣ **Influenza** – Current Season (*Strongly Recommended*)  
Do not upload previous seasonal flu vaccination! DO NOT OBTAIN PRIOR TO AUGUST. Please provide documentation of CURRENT season (September through April) influenza vaccination. An influenza vaccine is recommended annually.
- ♣ **COVID-19 Vaccination** (*Strongly Recommended*)  
Please provide documentation of at least one bivalent COVID-19 vaccine. COVID-19 vaccine and booster requirements for resident students may be updated at any time as NCC continues to monitor CDC recommendations and local COVID-19 data.

### TITERS (Bloodwork)

- ♣ **If immunization records are not available**, students are required to obtain titers to determine immunity status for the above listed requirements. **All titer results must be dated within three years.**
- ♣ Documentation of the Chickenpox disease is not considered acceptable for immunity, and a titer must be drawn.

### SUPPORTING DOCUMENTATION OPTIONS

- ♣ Immunization records can include your childhood and/or school immunization records – or a printout from your medical provider.
- ♣ Lab reports must contain titer results **dated within the past three years** showing level of immunity.

*For questions about health requirements, please contact:*

#### **Health and Wellness Center**

Northampton Community College  
College Center, Room 120  
3835 Green Pond Road  
Bethlehem, PA 18020

**Phone (610) 861-5365**

Name: \_\_\_\_\_  
Last First Middle

Student ID # \_\_\_\_\_

## TUBERCULOSIS SCREENING/TESTING

1. Have you ever had a positive TB skin test?  Yes  No
2. Have you ever had close contact with:  Yes  No
  - Anyone who was told they had TB?  Yes  No
  - Anyone who was tested by the health department or their physician because they were suspected to have tuberculosis?  Yes  No
  - Anyone who is currently in jail or has been in jail during the last 5 years?  Yes  No
3. Does your child currently have contact with anyone who is HIV-infected, homeless, resident of a nursing home, user of illegal drugs, or migrant farm worker?  Yes  No
4. Were you born in a country other than the United States?  Yes  No  
 If yes, list the name of the country \_\_\_\_\_
5. Have you ever traveled\* to/lived in another country(ies)?  Yes  No  
 If yes, list the name(s) of the country(ies) \_\_\_\_\_
6. Have you ever been vaccinated with BCG, a vaccine to prevent tuberculosis?  Yes  No

*\*The significance of the travel exposure should be discussed with a healthcare provider and/or the NCC Health & Wellness Center.*

If the answer to **ALL** of the above questions is **NO**, no further action is required.

If the answer to **ANY** of the above questions is **YES**, Northampton Community College **requires** TB testing for all students living in the Residence Hall. Students must submit results for either a Mantoux tuberculin skin test (TST), QuantiFERON-TB Gold or T-SPOT-TB blood test, or chest x-ray. Testing must be completed **within 6 months of moving into the Residence Hall**.

### Results of a Mantoux Tuberculin Skin Test (done within 6 months of moving into the Residence Hall)

Date Applied	Arm	Device	Antigen	Manufacturer	Signature

Date Read	Results (mm)	Signature
	<input type="checkbox"/> (+) <input type="checkbox"/> (-)    ____mm	

If a QuantiFERON-TB Gold or T-SPOT-TB blood test, or chest x-ray was performed, please **submit lab results dated within 6 months of moving into the Residence Hall**.

**Please print, type or stamp:**

Name of Licensed Provider \_\_\_\_\_

Address: \_\_\_\_\_

Phone \_\_\_\_\_

Signature of Licensed Provider \_\_\_\_\_ Date \_\_\_\_\_