



Northampton Community College

EARLY CHILDHOOD EDUCATION: Infant- Grade 4 HEALTH FORM

Campus: Main _____ Monroe _____ Pike _____

PART I – REPORT OF MEDICAL HISTORY

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

NAME: _____
last first middle

SEX: F M

HOME ADDRESS: _____
number/street

DATE OF BIRTH: ____/____/____
mo/day/yr

Social Security # ____/____/____

TELEPHONE () _____
city or town state zip country

SEMESTER SCHEDULE: Year _____ Fall Spring Summer ON-CAMPUS HOUSING check one Yes No

I. EMERGENCY NOTIFICATION

Name of Contact _____
Address _____
Phone () _____

Relationship _____
City _____ State _____ Zip _____
Business Phone () _____

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

	Yes	No	If Yes, 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, but not required)

Please submit a front and back copy of your health insurance card

III. 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 Northampton Community College Health Services Center, to the Early Childhood Education Program Director, to the appropriate health care agency in which I am completing clinical requirements and to the above named emergency contact.

Signature _____
Student signature (if 18 years of age or over)

Parent's signature (if student is under 18)

Date



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Part III- Tuberculosis Screening Test

Name _____ Social Security # ____ / ____ / ____
last first middle

DATE OF BIRTH: ____ / ____ / ____ Sex Male Female

TUBERCULOSIS SCREENING TEST

TUBERCULIN SKIN TESTS MUST BE CURRENT WITHIN 3 MONTHS

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

Follow-Up of significant tuberculin tests: _____
If induration is greater than 5 mm, chest x-ray is required. Attach written copy of x-ray report.

It is recommended for the student's protection that the following immunizations be up-to-date-

- Tetanus (within the past 10 years)
- Measles, Mumps, Rubella (MMR)
- Polio
- Hepatitis A & B

HEALTH PROVIDER: To the best of my knowledge the above information is correct.

Please print, type or stamp: Name of Family Physician _____
Address _____
Phone _____
Signature of Physician _____ Date _____