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:_____ SEX: ☐ F ☐ M
last first middle

HOME ADDESS:_____ DATE OF BIRTH: ___/___/___
number/street mo/day/yr

_____ Social Security # ___/___/___
city or town state zip country

TELEPHONE ( ) _____

SEMESTER SCHEDULE: Year_____ ☐ Fall ☐ Spring ☐ Summer ON-CAMPUS HOUSING check one ☐ Yes ☐ No

I. EMERGENCY NOTIFICATION
Name of Contact _____ Relationship _____
Address _____ City _____State _____ Zip _____
Phone ( ) _____ 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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IT IS RECOMMENDED YOU RETAIN COPIES OF YOUR HEALTH RECORD

PART II-REPORT OF MEDICAL EXAMINATION

An examination by a Physician is **required** prior to entry into clinical practice. Lab/internship is **prohibited** until the required medical forms are received and approved by the Director of the College Health Center.

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Name _____ Social Security # ____ / ____ / ____
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			

PLEASE INDICATE ANY PHYSICAL RESTRICTION_____
_____
_____
_____

MEDICATION ALLERGIES_____
_____

MEDICATIONS TAKEN ON A REGULAR BASIS_____
_____

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 _____

Please return completed original form to: College Health and Wellness Center
Northampton Community College
3835 Green Pond Road, Bethlehem PA 18020
Phone (610) 861-5365, FAX (610) 861-4545

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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 _____

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