



INTERNATIONAL STUDENT

HEALTH INFORMATION

For students, parents, and physicians

These forms must be completed by all international students and must be submitted prior to registration.

General Information

The Health Report and Physical Exam Form, located inside this publication, is the foundation of the student's medical record at Tompkins Cortland Community College. This record is reviewed by Student Health Services, and, if necessary, referred to a health practitioner for evaluation. It is then filed for reference to be used whenever a consultation for illness or a conference for health appraisal takes place. All information is confidential. You have been accepted and the information you provide on this form will not be used to influence your status at Tompkins Cortland Community College.

Return to all health information to:

**Student Health Center
Tompkins Cortland Community College
170 North Street
Dryden, NY 13053**

**Fax# 1 (607) 844-6533
healthcenter@tc3.edu**

PRIOR TO REGISTRATION

Physical Examination (To be completed by Medical Provider- Please print or type all information)

Patient Name: _____ / _____ / _____
 Last First Middle mm/ dd/ yyyy
 Date of Exam

Date of Birth: __/__/____ Gender: Male ___ Female ___
 m m / d d / y y y y

Blood Pressure: _____ Pulse: _____ Height: _____ Weight: _____

Vision: O.S. _____ O.D. _____ With correction? ___ Yes ___ No

Clinical Evaluation

Check each item in proper column. Check Normal or Abnormal or write N.E. if not evaluated.

	Normal	Abnormal	Comments
1. HEENT			
2. Neck			
3. Heart			
4. Lungs			
5. Breasts			
6. Abdomen			
7. Genitourinary			
8. Musculoskeletal			
9. Neuro/Psych			
10. Pelvic (optional)			

Please provide a brief explanation of all items checked "abnormal."

Medications taking at present:

Allergies (drug or food):

Activity restrictions?

Is this patient mentally, physically and emotionally ready for college life? If no, please explain your answer.

Medical Provider: Name (print) _____ **Title** _____
Address _____

Medical Provider Signature: _____ **Date:** __/__/____

Immunization Screening Record: to be completed by Medical Provider

Patient Name: _____ Date of Birth: _____
 Last First Middle mm / d d / y y y y

REQUIRED IMMUNIZATIONS: Must provide actual dates.

MMR Requirements					
Must be filled out by Medical Provider					
MANDATORY ALL DOSES MUST be given ON OR AFTER 12 Months of age or they are NOT valid to attend TC3.	MMR Vaccines		Positive Blood Titers *		
	Given at 12 months or older				
	MMR 1 _ _ / _ _ / _ _ _ _ mm/dd/yyyy	And / Or	Measles + _ _ / _ _ / _ _ _ _ mm/dd/yyyy	And / Or	History of Disease
	MMR 2 _ _ / _ _ / _ _ _ _ mm/dd/yyyy		Mumps + _ _ / _ _ / _ _ _ _ mm/dd/yyyy		Measles _ _ / _ _ / _ _ _ _ mm/dd/yyyy
	OR		Rubella + _ _ / _ _ / _ _ _ _ mm/dd/yyyy		Mumps _ _ / _ _ / _ _ _ _ mm/dd/yyyy
	Measles 1 _ _ / _ _ / _ _ _ _ mm/dd/yyyy		*Attach lab results if this section is filled out.		History of Rubella is not acceptable
	Measles 2 _ _ / _ _ / _ _ _ _ mm/dd/yyyy				
	Mumps 1 _ _ / _ _ / _ _ _ _ mm/dd/yyyy				
Rubella 1 _ _ / _ _ / _ _ _ _ mm/dd/yyyy					
MENINGITIS RESPONSE					
Write date of vaccination OR Student signs to decline					
I have received the Menomune™ (MPSV4) vaccine within the past 5 years. <i>If received prior to February 2005, the Menomune™ vaccine protects 3-5 years from when received.</i> Date Received _ _ / _ _ / _ _ _ _ mm/dd/yyyy					
I have received the Menactra™ (MCV4) vaccine within the past 10 years. Date received: _ _ / _ _ / _ _ _ _ mm/dd/yyyy					
-OR- I choose to decline the Meningitis Vaccine by signing below. I have read, or have had explained to me, the information regarding meningococcal meningitis disease. <i>I understand the risks of not receiving the vaccine.</i> Student Signature _____ (Parent/Guardian signs if student is under 18)					
Tuberculosis (TB) Screening and Symptom Checklist					
Please complete on page 5					

Medical Provider: Name (print) _____ **Title** _____
Address _____

Medical Provider Signature: _____ **Date:** _ _ / _ _ / _ _ _ _

Must be filled out by **Medical Provider:** **Student Name** _____

Date of Birth __/__/____
mm/dd/yyyy

Recommended Immunizations:

Hepatitis A	Dose #1 __/__/____ mm/dd/yyyy	Dose #2 __/__/____ mm/dd/yyyy	
Hepatitis B	Dose #1 __/__/____ mm/dd/yyyy	Dose #2 __/__/____ mm/dd/yyyy	Dose #3 __/__/____ mm/dd/yyyy
Tetanus Series/ Booster	Date Series Completed __/__/____ mm/dd/yyyy	Date of Last Booster __/__/____ mm/dd/yyyy	
Polio	Date Series Completed __/__/____ mm/dd/yyyy		
Varicella (Chicken Pox)	Date Series Completed __/__/____ mm/dd/yyyy	OR History of Disease __/__/____ mm/dd/yyyy	OR Titer Results (Attach Lab Results)

Tuberculosis (TB) Screening

Please ask the patient the following questions:

	YES	NO
Have you ever had a positive TB skin test?		
Have you ever had close contact with anyone who was sick with TB?		
Have you ever been vaccinated with BCG?		
Have you had a chest X-ray in the last five years? (if Yes, please attach results)		

Symptom Check*

Please ask the patient these yes or no questions.

During the last six months, have you experienced:

	Yes	No
Low grade fever or chills?		
Night sweats?		
Loss of appetite?		
Weight loss?		
Fatigue?		
Swollen nodes?		
Sore throat?		
Chest pain?		
Shortness of Breath?		
Productive cough?		
Bloody sputum?		
New medical problems?		
New medications?		

**If 'Yes' is checked for any symptoms, a tuberculin skin test must be performed (if no history of previous positive skin test).*

Tuberculin Skin Test:

Within 6 months of attending TC3

Date: __/__/____
mm/dd / yyyy

Result: _____mm induration

All positive tuberculin skin tests must be followed by a chest x-ray.

Chest X-ray:

Date: __/__/____ **Attach results.**
mm/dd/yyyy

Medical Provider: Name (printed) _____ **Title** _____

Address: _____

Medical Provider Signature: _____ **Date:** __/__/____