



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**

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. 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					
<p style="color: red; font-weight: bold; margin: 0;"><u>MANDATORY</u> ALL DOSES <u>MUST</u> be given ON OR AFTER first birthday or they will <u>NOT</u> be valid to attend TC3.</p>	MMR Vaccine Must be <u>after</u> January 1, 1968	And / Or	<u>Positive Blood Titers</u> *	And / Or	History of Disease
	MMR 1 _ _ / _ _ / _ _ _ _ mm/dd/yyyy		Measles + _ _ / _ _ / _ _ _ _ mm/dd/yyyy		Measles _ _ / _ _ / _ _ _ _ mm/dd/yyyy
	MMR 2 _ _ / _ _ / _ _ _ _ mm/dd/yyyy		Mumps + _ _ / _ _ / _ _ _ _ mm/dd/yyyy		Mumps _ _ / _ _ / _ _ _ _ mm/dd/yyyy
	OR		Rubella + _ _ / _ _ / _ _ _ _ mm/dd/yyyy		<p>History of Rubella is <u>not</u> acceptable</p>
	Measles 1 _ _ / _ _ / _ _ _ _ mm/dd/yyyy		<p>*Attach lab results if this section is filled out.</p>		
	Measles 2 _ _ / _ _ / _ _ _ _ mm/dd/yyyy				
	Mumps 1 _ _ / _ _ / _ _ _ _ mm/dd/yyyy				
	Rubella 1 _ _ / _ _ / _ _ _ _ mm/dd/yyyy				

Tuberculosis (TB) Screening and Symptom Checklist
 Please complete on page 5

MENINGITIS RESPONSE
 Check box and fill out accordingly.

<input type="checkbox"/>	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
<input type="checkbox"/>	I have received the Menactra™ (MCV4) vaccine within the past 10 years. Date received: _ _ / _ _ / _ _ _ _ mm/dd/yyyy
-OR -	
<input type="checkbox"/>	Declined immunization against meningococcal meningitis disease. 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)

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

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

