I.D. # _____
For office use only

MEDICAL FORM

ENROLLMENT INFORMATION

Type of Student: ☐ New ☐ Transfer ☐ Former ☐ International Status: ☐ Full-time ☐ Part-time

Semester: ☐ Fall ☐ Spring ☐ Summer Year: 20_____ Housing: ☐ On-Campus ☐ Off-Campus

Gender ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

DEMOGRAPHIC INFORMATION

Full Legal Name:_____
Last (Family Name or Surname) First (Given Name) Middle or Maiden Preferred First Name

Permanent Address_____
Number and Street

_____
City/Town County State/Province Zip/Postal Code Country

Home Phone: (_____)_____-_____ Social Security Number: _____-_____-_____ Date of Birth: ____/____/____
mm dd yy

FAMILY HEALTH HISTORY

Have any of your relatives had any of the following diseases or disorders? If yes, please explain relationship to you.

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Cancer	☐	☐	_____	Mental Illness	☐	☐	_____
Diabetes	☐	☐	_____	Migraine Headaches	☐	☐	_____
Epilepsy	☐	☐	_____	Tuberculosis	☐	☐	_____
Heart Disease	☐	☐	_____				

PERSONAL HEALTH HISTORY

Have you ever experienced any of the following?

	YES	NO		YES	NO		YES	NO
Anemia/Blood Disease	☐	☐	Epilepsy	☐	☐	Mononucleosis	☐	☐
Appetite Loss	☐	☐	Fainting	☐	☐	Mumps	☐	☐
Arthritis	☐	☐	Fibromyalgia	☐	☐	Obesity	☐	☐
Asthma	☐	☐	Hay Fever	☐	☐	Paralysis	☐	☐
Back Problem	☐	☐	Head Injury	☐	☐	Physical Limitations	☐	☐
Bronchitis/Chronic Cough	☐	☐	Headaches/Recurrent	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Hearing Problems	☐	☐	Scarlet Fever	☐	☐
Chicken Pox/Varicella	☐	☐	Heart Murmur or Disease	☐	☐	Severe Cramps	☐	☐
Chronic Diarrhea	☐	☐	Hepatitis	☐	☐	Shortness of Breath	☐	☐
Chronic Ear Infections	☐	☐	Hernia	☐	☐	Sinusitis	☐	☐
Colitis, Ulcerative/Spastic	☐	☐	HIV Positive	☐	☐	Sprains, Recurrent	☐	☐
Congenital Disease	☐	☐	Hypertension	☐	☐	Stomach Trouble	☐	☐
Convulsions	☐	☐	Insomnia	☐	☐	Strep Throat, Frequent	☐	☐
Cystitis	☐	☐	Joints, Injury or Disease	☐	☐	Thyroidism, Hyper/Hypo	☐	☐
Depression	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Diabetes/Hypoglycemia	☐	☐	Malaria	☐	☐	Unconsciousness	☐	☐
Dizziness	☐	☐	Measles	☐	☐	Venereal Disease	☐	☐
Eating Disorders	☐	☐	Mental Disorder	☐	☐	Vision Problems	☐	☐
Eczema	☐	☐	Migraines	☐	☐	Other	☐	☐

If you answered yes to any of the previous questions, please explain._____

_____

_____

REQUIRED IMMUNIZATIONS

Hepatitis B Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age.

Immunization (Hepatitis B) Dose #1 _____/_____/_____, Dose #2 _____/_____/_____, Dose #3 _____/_____/_____. **OR**
mm dd yy mm dd yy mm dd yy

Immunization (Combined Hepatitis A and B) #1 _____/_____/_____, #2 _____/_____/_____, #3 _____/_____/_____.
mm dd yy mm dd yy mm dd yy

Hepatitis A (**Not required**) #1 _____/_____/_____, #2 _____/_____/_____.
mm dd yy mm dd yy

Measles, Mumps, Rubella (MMR) Two doses are required for students born after January 1, 1957.

MMR Dose #1, given at age 12-15 months or later _____/_____/_____.
mm dd yy

MMR Dose #2, given at age 4-6 years or later, and at least one month after first dose _____/_____/_____.
mm dd yy

Tetanus Td booster dose or Primary series within the last ten years.

Booster: Td dose within the last ten years prior to matriculation Date of booster, _____/_____/_____
mm dd yy

OR

Booster: Tdap (preferred) to replace a single dose of Td for booster immunization Date of booster, _____/_____/_____
mm dd yy

OR

Primary Series within the last ten years prior to matriculation #1____/____/____,#2____/____/____,#3____/____/____.
mm dd yy mm dd yy mm dd yy

Varicella (Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

History of Disease Yes _____ No _____ Year_____ or Birth in U.S. before 1980 Yes _____ No _____

Varicella antibody ____/____/____ Result: Reactive _____ Non-reactive _____
mm dd yy

Immunization
Dose #1_____/_____/_____
mm dd yy

Dose #2 older _____/_____/____ Dose #2 given at least 12 weeks after first dose ages 1-12 years
mm dd yy and at least 4 weeks after first dose if age 13 years or older.

Do you have any drug sensitivities? ☐ yes ☐ no If yes, please explain._____

Do you have any non-drug allergies? ☐ yes ☐no If yes, please explain._____

Do you take any medications regularly or frequently? ☐ yes ☐ no If yes, please explain._____

Have you had any medical treatment or hospital admission within the last five years? ☐ yes ☐ no

If yes, please list date and reason._____

_____

_____

Meningitis: Due to Georgia law, Toccoa Falls College requires students taking 6 or more credit hours to sign a document stating that they have received a vaccination against meningococcal disease or reviewed the information and declined to be vaccinated. This information is required by law to be on file with your health records.

Meningococcal Disease Facts

- Meningococcal disease is a serious infection caused by bacteria, most commonly causing meningitis (an infection of the membranes that surround the spinal cord and brain) or sepsis (an infection of blood that affects many organ systems).
- College freshmen, particularly those living in dorms, have a modestly increased risk of getting the disease compared with other persons of the same age. Up to 100 cases occur among the 15 million college students in the United States each year, with 5-15 deaths.
- Bacteria are spread from person-to-person through secretions from the mouth and nose, transmitted through close contact. Casual contact or breathing in the same air space is not considered sufficient for transmission.
- Common symptoms include: stiff neck, headache, fever, sensitivity to light, sleepiness, confusion, and seizures. Invasive meningococcal disease, or blood infection with the organism, causes fever and rash.
- The disease can be treated with antibiotics, but treatment must be started early. Even with treatment, some patients may die. Survivors may be left with a severe disability such as the loss of a limb.
- Immunization against meningococcal disease will decrease the risk of the disease.

Meningococcal Vaccine Facts

- A meningococcal polysaccharide vaccine is available for those who wish to pay for it. (Usually through your County Health Department.)
- Vaccine protects against 4 of the 5 most common types of meningococcal bacteria and protection typically lasts 3-5 years.
- Vaccination may decrease the risk of meningococcal disease; however, it does not eliminate the risk because the vaccine does not protect against all types of meningococcal bacteria. Approximately 50-70% of disease among college students is likely to be vaccine-preventable.

Please complete the following:

I have received the vaccine against Meningococcal Disease. Name_____,_____
Last First
Please Print Clearly

Date of Vaccination _____/_____/_____ Signature_____
Mo day year

OR

I have read the above information concerning the Meningococcal Disease Georgia Law, disease facts, and vaccine facts. I understand the seriousness of this disease and that immunization will decrease the risk, yet desire to waive having the vaccination.

Name_____, _____
Last First
Please Print Clearly

Signature_____ Date _____

If you are <u>under 18</u>, parental or guardian signature is required.

Signature_____ Date _____

EMERGENCY CONTACT AND HEALTH INSURANCE INFORMATION

Emergency Contact Name:_____

Home Phone Number:_____

Work Phone Number:_____

Emergency Contact Relationship to Student:_____

Primary Insurance Company Name:_____

Name of Policy Holder:_____ Relationship to Student:_____

Policy Holder's Date of Birth: _____/_____/_____ Effective Date:_____/_____/_____
mm dd yy mm dd yy

Group and/or ID Number:_____ Policy Number:_____

Claims Address and/or Phone Number:_____

_____

Many insurance companies restrict coverage when students are away from home. Please check with your company to know how best to be covered. **Please have a copy of your primary insurance card.** Resident students are automatically covered under the school's Basic Health Insurance Plan. This is a very limited plan {total benefit maximum is only $2,000.00}. Nonresident, fulltime students have the option to buy this insurance plan. For further insurance questions, please call Health Services, 706-886-7299 ext. 5304.
If you are a resident student 23 years of age or younger, with no primary insurance, and your parents are employed, you will be required to present a letter from your parents (or their insurance company) of "Proof of No Coverage".

CERTIFICATION STATEMENT

By signing my name below I certify that all the information provided is true and complete to the best of my knowledge. I also certify that I have no abnormality, limitation, or restriction not mentioned on this form. I agree to notify the Health Services of any changes that occur in my physical or mental health prior to and during my attendance at Toccoa Falls College. I also understand that if I desire to participate in intercollegiate athletics, I must have a sports physical (form available through Sports Department or Health Services) on file before I will be allowed to begin conditioning, practice, or competition.

_____ _____
Student Signature Date

Students who will be under the age of 18 by check-in day must also have their parent or guardian complete and submit a Consent for Treatment Form before attending classes.

Students with questions concerning the Medical Form should call Health Services at 706-886-7299 Ext. 5304.
The information that you send to Toccoa Falls College is held in strictest confidentiality.
It can be released only with your written permission.

Please return this form (and Consent Form or Sports Physical, if applicable) to:

Toccoa Falls College
Health Services
P.O. Box 800003
Toccoa Falls, GA 30598

Student's Name _____
Please Print

TUBERCULOSIS (TB) SCREENING/TESTING
Please answer the following questions:

Have you ever had a positive TB skin test? Yes _____ No _____

Have you ever had close contact with anyone who was sick with TB? Yes _____ No _____

Were you born in one of the countries listed in box below and arrived in the U.S. within the past 5 years? Yes _____ No _____ (If yes, please circle ⬭ the country.)

Have you ever traveled to/in one or more of the countries listed in the box below? Yes _____ No _____ (If yes, please check ✔the country/ies.)

Have you ever been vaccinated with BCG? Yes _____ No _____

If the answer is YES to any of the above questions, Toccoa Falls College requires that a health care provider complete the Tuberculosis Risk Assessment Form found on the back of this page (to be completed prior to the start of classes).

If the answer to all of the above questions is NO, no further testing or action is required.

Afghanistan	Cote d'Ivoire	Korea-DPR	Niger	Sri Lanka
Algeria	Croatia	Korea-Republic	Nigeria	Sudan
Angola	Djibouti	Kuwait	Niue	Suriname
Anguilla	Dominican Republic	Kyrgyzstan	N. Mariana Islands	Syrian Arab Republic
Argentina	Ecuador	Lao PDR	Pakistan	Swaziland
Armenia	Egypt	Latvia	Palau	Tajikistan
Azerbaijan	El Salvador	Lesotho	Panama	Tanzania-UR
Bahamas	Equatorial Guinea	Liberia	Papua New Guinea	Thailand
Bahrain	Eritrea	Lithuania	Paraguay	Timor-Leste
Bangladesh	Estonia	Macedonia-TFYR	Peru	Togo
Belarus	Ethiopia	Madagascar	Philippines	Tokelau
Belize	Fiji	Malawi	Poland	Tonga
Benin	French Polynesia	Malaysia	Portugal	Tunisia
Bhutan	Gabon	Maldives	Qatar	Turkey
Bolivia	Gambia	Mali	Romania	Turkmenistan
Bosnia & Herzegovina	Georgia	Marshall Islands	Russian Federation	Tuvalu
Botswana	Ghana	Mauritania	Rwanda	Uganda
Brazil	Guam	Mauritius	St. Vincent & The Grenadines	Ukraine
Brunei Darussalam	Guatemala	Mexico	Sao Tome & Principe	Uruguay
Bulgaria	Guinea	Micronesia	Saudi Arabia	Uzbekistan
Burkina Faso	Guinea-Bissau	Moldova-Rep.	Senegal	Vanuatu
Burundi	Guyana	Mongolia	Seychelles	Venezuela
Cambodia	Haiti	Montenegro	Sierra Leone	Viet Nam
Cameroon	Honduras	Morocco	Singapore	Wallis & Futuna Islands
Cape Verde	India	Mozambique	Solomon Islands	W. Bank & Gaza Strip
Central African Rep.	Indonesia	Myanmar	Somalia	Yemen
Chad	Iran	Namibia	South Africa	Zambia
China	Iraq	Nauru	Spain	Zimbabwe
Colombia	Japan	Nepal		
Comoros	Kazakhstan	New Caledonia		
Congo	Kenya	Nicaragua		
Congo DR	Kiribati			

TUBERCULOSIS (TB) RISK ASSESSMENT
(Required only if yes to any of the questions asked regarding Tuberculosis Screening)

Health Care Provider

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____
If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST) (TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0".
The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: _____/_____/_____ Date Read: _____/_____/_____
mm dd yy mm dd yy

Result: _____ mm of induration **Interpretation: positive_____ negative_____

Date Given: _____/_____/_____ Date Read: _____/_____/_____
mm dd yy mm dd yy

Result: _____ mm of induration **Interpretation: positive_____ negative_____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: _____/_____/_____ (specify method) QFT-G QFT-GIT other_____
mm dd yy

Result: negative_____ positive_____ intermediate_____

Date Obtained: _____/_____/_____ (specify method) QFT-G QFT-GIT other_____
mm dd yy

Result: negative_____ positive_____ intermediate_____

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: _____/_____/_____ Result: normal_____ abnormal_____
mm dd yy

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1month; taking a TNF-α antagonist
- Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant amount of timeα
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

If positive, please provide the student a chest x-ray and a treatment plan to be given to the Toccoa Falls College Health Services Office and Stephens County Health Department.

HEALTH CARE PROVIDER Signature _____ Date_____

Name _____ Address _____
Please Print

Phone (_____) _____ _____