NORTHAMPTON COMMUNITY COLLEGE

HEALTH FORM

FUNERAL SERVICE EDUCATION PROGRAM

For questions about health requirements, please contact:

Health and Wellness Center

Northampton Community College
College Center, Room 120
3835 Green Pond Road
Bethlehem, PA 18020

Phone: 610-861-5365

PART I – REPORT OF MEDICAL HISTORY

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

Student Name: _____ **Student ID #:** _____
Last First Middle

Home Address: _____ Gender: ☐ Male ☐ Female ☐ Other _____

City/State/Zip: _____ Preferred: ☐ He/Him ☐ She/Her ☐ They/Them

Home Phone: _____ Cell Phone: _____

Email Address: _____ **Date of Birth**: _____

Program: **Funeral Service Education** On Campus Housing: ☐ Yes ☐ No

Semester: ☐ FA ☐ SP ☐ SU Year _____ Campus: ☐ Main ☐ Fowler ☐ Monroe

I. EMERGENCY NOTIFICATION

Name of Contact: _____ Relationship: _____

Home Address: _____ City/State/ Zip: _____

Primary Phone: _____ Alternate Phone: _____

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

	Yes	No	Please 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 (Required) – Student must upload a copy of current health insurance card (front and back) to myRecordTracker®. Student is required to have valid health insurance for the duration of the program, and must notify the Program Director and the Health and Wellness Center of any change in health insurance which occurs during the program, and upload a copy of the new insurance card.

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 Program Director and appropriate designee(s), to the Northampton Community College Health and Wellness Center, to the appropriate health care agency in which I am completing clinical requirements, and/or to the above-named emergency contact.

_____ _____

Student signature (Parent/Guardian if under 18 years of age) *Date*

PART II-REPORT OF MEDICAL EXAMINATION

A physical examination completed **within 6 months of the start of the clinical experience** by a licensed medical provider (MD, DO, CRNP, or PA-C) is **required** prior to entry into clinical practice. Clinical work is **PROHIBITED** until the required medical forms are uploaded and verified.

Name:_____ **Student ID:**_____ **DOB:**_____

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			
Exposure to Hepatitis A, B, or C			*If positive for exposure, please submit titers.*

Allergies	
Medications taken on a regular basis	

****IMPORTANT** LICENSED PROVIDER, PLEASE INITIAL TO CERTIFY THE FOLLOWING:**	**INITIALS**
I certify that the applicant is free from communicable diseases in the communicable state.	
I certify that the applicant has no medical conditions or restrictions which will prevent the applicant from performing the essential functions of the job. (If the applicant has restrictions that require accommodation, please note them in the comments section below.)	
Comments *(if applicant has any limitations, please explain)*:	

Please print, type or stamp:

Name of Licensed Provider_____

Address:_____

Phone_____

Signature of Licensed Provider_____ Date_____

CLINICAL REQUIREMENTS

To meet the requirements set forth by NCC, Clinical Sites and OSHA, you will need to obtain and upload to myRecordTracker® documentation for the following immunizations and tests before beginning your clinical or field study experience.

IMMUNIZATIONS (Vaccinations)

All students are required to UPLOAD **immunization records** to myRecordTracker® for the following:

- **Hepatitis B** – 3 doses
- **TDAP** – Tetanus Diphtheria Acellular Pertussis *(Dated within 10 years)*

HEPATITIS B SURFACE ANTIBODY, QUANTITATIVE TITER

- **All Students** are required to obtain the **Hepatitis B Surface Antibody, QUANTITATIVE Titer** to determine immunity status and UPLOAD the **lab report** to myRecordTracker®**. Titer results must be dated within the past three years.**

HEPATITIS B REPEAT SERIES OR BOOSTER *(Required if titer shows no or low immunity)*

- If the Hepatitis B Surface Antibody, Quantitative Titer shows no immunity, the repeat series of three doses should be started immediately.
- If the titer shows low immunity, a booster dose should be given immediately. The repeat titer should be given one month after the booster or last dose.
- Any repeat doses, booster, and titer reports must be uploaded to myRecordTracker® each time they are received.

TITERS (Bloodwork)

- **If immunization records are not available,** students are required to obtain titers to determine immunity status for the above listed requirements. **All titer results must be dated within three years.**

SUPPORTING DOCUMENTATION OPTIONS

- Immunization records can include your childhood and/or school immunization records – or a print out from your medical provider.
- Lab reports must contain titer results **dated within the past three years** showing level of immunity.

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