NORTHAMPTON COMMUNITY COLLEGE
HEALTH & WELLNESS CENTER

Housing & Residence Life

HEALTH FORM PART I – REPORT OF MEDICAL HISTORY

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

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/Major: _____ On Campus Housing: ☒ Yes ☐ No

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

I. EMERGENCY NOTIFICATION

Name of Contact: _____ Relationship: _____

Address: _____

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 (Recommended) – Student should upload a copy of current health insurance card (front and back) to myRecordTracker®. It is recommended that students have valid health insurance while using on-campus housing, and notify the Residence Hall Director and/or Health and Wellness Center of any change in health insurance which occurs during the academic year, and upload a copy of the new insurance card. If you choose not to provide this information, please upload a typed or handwritten paper stating that you do not wish to provide health insurance documentation.

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 Residence Hall Director and appropriate designee(s), to the Northampton Community College Health and Wellness Center, to the appropriate health care agency, 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 moving into the residence hall**, and every 2 years thereafter, by a licensed medical provider (MD, DO, CRNP, or PA-C) is **required**. Moving into the residence hall is **PROHIBITED** until the required medical forms are uploaded and verified.

Name:_____ **Student ID:**_____ **DOB:**_____
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			
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 above-named student is free from communicable diseases in the communicable state.	
I certify that the above-named student has no medical conditions or restrictions. (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 to reside in On-Campus housing.

IMMUNIZATIONS (Required Vaccinations)

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

- **Varicella** (Chickenpox) – 2 doses after age 12 months
- **MMR*** – 1st dose after age 12 months, and 2nd dose after age 4 years
- **Hepatitis B** – 3 doses *(Recommended)*
- **Meningococcal A-C-W-Y** *(After Age 16, and within the past 5 years)*
- **TDAP** – Tetanus Diphtheria Acellular Pertussis *(Dated within 10 years)*

IMMUNIZATIONS (Strongly Recommended)

It is **strongly recommended** that all students obtain and submit documentation for the following:

- **Influenza** – Current Season *(Strongly Recommended)*
  Do not upload previous seasonal flu vaccination! DO NOT OBTAIN PRIOR TO AUGUST. Please provide documentation of CURRENT season (September through April) influenza vaccination. An influenza vaccine is recommended annually.
- **COVID-19 Vaccination** *(Strongly Recommended)*
  Please provide documentation of at least one bivalent COVID-19 vaccine. COVID-19 vaccine and booster requirements for resident students may be updated at any time as NCC continues to monitor CDC recommendations and local COVID-19 data.

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.**
- Documentation of the Chickenpox disease is not considered acceptable for immunity, and a titer must be drawn.

SUPPORTING DOCUMENTATION OPTIONS

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

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

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

TUBERCULOSIS SCREENING/TESTING

1. Have you ever had a positive TB skin test? ☐ Yes ☐ No
2. Have you ever had close contact with:
   - Anyone who was told they had TB? ☐ Yes ☐ No
   - Anyone who was tested by the health department or their physician because they were suspected to have tuberculosis? ☐ Yes ☐ No
   - Anyone who is currently in jail or has been in jail during the last 5 years? ☐ Yes ☐ No
3. Does your child currently have contact with anyone who is HIV-infected, homeless, resident of a nursing home, user of illegal drugs, or migrant farm worker? ☐ Yes ☐ No
4. Were you born in a country other than the United States? ☐ Yes ☐ No
   If yes, list the name of the country_____
5. Have you ever traveled* to/lived in another country(ies)? ☐ Yes ☐ No
   If yes, list the name(s) of the country(ies)_____
6. Have you ever been vaccinated with BCG, a vaccine to prevent tuberculosis? ☐ Yes ☐ No

**The significance of the travel exposure should be discussed with a healthcare provider and/or the NCC Health & Wellness Center.*

If the answer to **ALL** of the above questions is **NO**, no further action is required.

If the answer to **ANY** of the above questions is **YES**, Northampton Community College **requires** TB testing for all students living in the Residence Hall. Students must submit results for either a Mantoux tuberculin skin test (TST), QuantiFERON-TB Gold or T-SPOT-*TB* blood test, or chest x-ray. Testing must be completed **within 6 months of moving into the Residence Hall**.

Results of a Mantoux Tuberculin Skin Test (done within 6 months of moving into the Residence Hall)

Date Applied	Arm	Device	Antigen	Manufacturer	Signature

Date Read	Results (mm)	Signature
	☐ (+) ☐ (–) ____mm	

If a QuantiFERON-TB Gold or T-SPOT-*TB* blood test, or chest x-ray was performed, please submit lab results dated within 6 months of moving into the Residence Hall.

Please print, type or stamp:

Name of Licensed Provider_____

Address:_____

Phone_____

Signature of Licensed Provider_____ Date_____