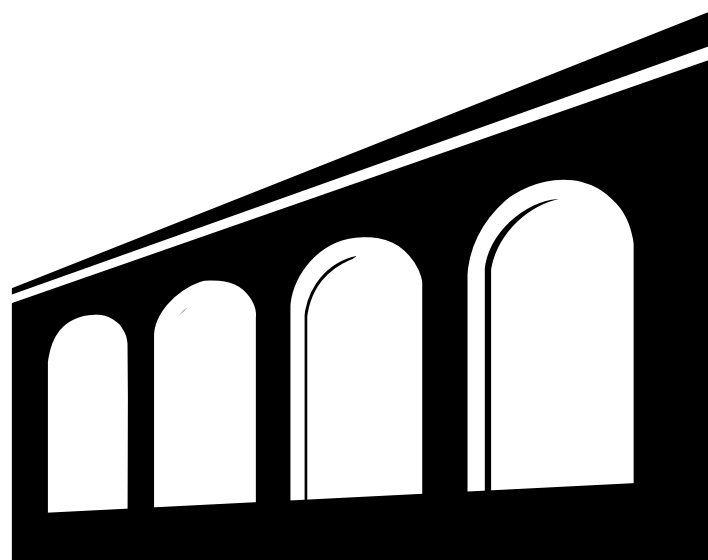


Student Medical Form



VGCC

VANCE-GRANVILLE COMMUNITY COLLEGE

STUDENT MEDICAL FORM

VANCE-GRANVILLE COMMUNITY COLLEGE

INSTRUCTIONS FOR COMPLETING STUDENT MEDICAL FORM

1. Complete the four-page insert:

- Physical Examination
- Immunization Record
- Report of Medical History
- Family & Personal Health History

2. Return the form to:

Vance-Granville Community College
Student Services
P.O. Box 917
Henderson NC 27536

3. If you have questions about the form, please call Student Services: 252-492-2061

4. See the attached Guidelines for completing the Immunization Record on the inside back page of this package.

IMMUNIZATION RECORD

(Please print in black ink) To be completed and signed by physician or clinic
 A complete immunization record from a physician or clinic may be attached to this form.

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH (mo./day/year)	* SOCIAL SECURITY NUMBER
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SECTION A: REQUIRED IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
DTP	(#1)	(#2)	(#3)	(#4)
Td Booster				
Polio				
MMR (after first birthday)				
MR (after first birthday)				
Measles (after first birthday)			**Disease Date	**** Titer Date & Result
Mumps			*** (Disease Date Not Accepted)	**** Titer Date & Result
Rubella			*** (Disease Date Not Accepted)	**** Titer Date & Result

SECTION B: RECOMMENDED IMMUNIZATIONS The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

	mo./day/year	mo./day/year	mo./day/year	
Hepatitis B series				**** Titer Date & Result
Varicella (chicken pox) series of two doses or immunity by positive blood			Disease Date	**** Titer Date & Result
Meningococcal				
Tuberculin (PPD) Test (within 12 months)	Date read mm induration			
Chest x-ray, if positive PPD	Date Results			
Treatment, if applicable	Date			

SECTION C: OPTIONAL IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year
Haemophilus Influenzae Type B			
Pneumococcal			
Hepatitis A Series			
Typhoid (specify type)			
Other			

Signature or Clinic Stamp REQUIRED:

 Signature of Physician/Physician Assistant/Nurse Practitioner

 Date

 Print Name of Physician/Physician Assistant/Nurse Practitioner

 Area Code / Phone Number

 Office Address

 City

 State

 Zip Code

* Provision of Social Security Number is voluntary, is requested solely for administrative convenience and recordkeeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.
 ** Must repeat Rubella (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.
 *** Only laboratory proof of rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from physician, is not acceptable.
 **** Attach lab report.

REPORT OF MEDICAL HISTORY

(Please print in black ink)

To be completed by student

LAST NAME FIRST NAME MIDDLE NAME * SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo./day/yr.) GENDER MALE FEMALE MARITAL STATUS S M OTHER

CLASS YOU ARE ENTERING (circle):
FR. SO. JR. SR. GRAD. PROF.

PREVIOUSLY ENROLLED HERE YES NO
IF YES, DATES _____

SEMESTER ENTERING (circle) FALL SPRING
SUMMER 1 SUMMER 2 OTHER YEAR 20 ____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

NAME OF POLICY HOLDER * SOCIAL SECURITY NUMBER EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER IS THIS AN HMO/PPO/MANAGED CARE PLAN? YES NO

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

FAMILY & PERSONAL HEALTH HISTORY

(Please print in black ink)

To be completed by student

Has any person related by blood had any of the following?

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer — type:			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT _____ WEIGHT _____

Have you ever had, or do you now have any of the following: (please check at right of each item, and if yes, year of first occurrence).

	Yes	No	Year		Yes	No	Year		Yes	No	Year				
High blood pressure				Hay fever				Jaundice or hepatitis				Kidney stone			
Rheumatic fever				Allergy injection therapy				Rectal disease				Protein or blood in urine			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Hearing loss			
Pain or pressure in chest				Concussion				Hernia				Sinusitis			
Shortness of breath				Frequent or severe headaches				Easy fatigability				Severe menstrual cramps			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Irregular periods			
Pneumonia				Severe head injury				Eye trouble except need for glasses				Sexually transmitted disease			
Chronic cough				Paralysis				Bone, joint or other deformity				Blood transfusion			
Head or neck radiation treatments				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				Drug use			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Smoke 1+pack cigarettes/week			
Diabetes				Pilonidal cyst				Broken bone (specify)				Regularly exercise			
Serious skin disease				Frequent vomiting				Kidney infection				Wear seat belt			
Mononucleosis				Gall bladder trouble or gallstones				Bladder infection				Other (specify)			

Please list any drugs, medicines, birth control pill, vitamins and minerals (prescription or nonprescription) you use and indicate how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
 Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
 Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
 Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

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Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe.)			
Have you ever been a patient in any type of hospital? (Specify when, where and why.)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain.)			
Is there loss or seriously impaired function of any paired organs? (Please describe.)			
Other than for a routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe.)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details.)			

IMPORTANT INFORMATION...PLEASE READ AND COMPLETE

STATEMENT BY STUDENT OR PARENT/GUARDIAN, IF STUDENT IS UNDER AGE 18:

- (A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.
- (B) I hereby authorize any medical treatment for myself (son/daughter) that may be advised or recommended by the physicians of the student health service. (Not applicable to community colleges.)
- (C) I am aware that the student health service does charge for some services, and that I may be billed through the university cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. (Not applicable to community colleges.)

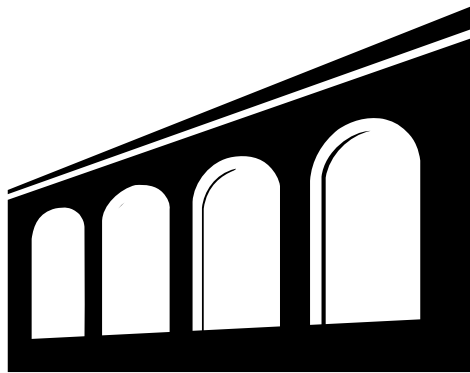
Signature of Student

Date

Signature of Parent/Guardian, if student under age 18

Date

Vance-Granville Community College
P.O. Box 917
Henderson, NC 27536
(252) 492-2061



Vance-Granville Community College is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools to award certificates, diplomas, and associate degrees. Contact the Commission on Colleges at 1866 Southern Lane, Decatur, Georgia 30033-4097 or call (404) 679-4500 for questions about the accreditation of Vance-Granville Community College. The Commission on Colleges should be contacted only if there is evidence that appears to support an institution's significant non-compliance with a requirement or standard. Vance-Granville Community College is an equal opportunity, affirmative action institution. The college serves all students regardless of race, creed, color, age, sex, national origin, or disabling conditions. Vance-Granville Community College is a Tobacco-Free College.