Forsyth Tech COMMUNITY COLLEGE

Medical Unit Secretary Program
STUDENT MEDICAL FORM
(Confidential)

Directions for Completion

1. A completed medical record is required of all students entering the Medical Unit Secretary Program.
2. Your healthcare provider should complete the **Immunization Record** (page 3) of this form. The remaining pages are to be completed you.
3. Failure to submit the Student Medical Form and other required documentation by the specified due date will affect your enrollment in the program.
4. You will receive information about how to submit this form and other required documentation from your program coordinator/chair or lead instructor.

Required Immunizations for All Students					
Tdap/Td	Total of 1 vaccination within the last 10 years				
MMR	Total of 2 vaccinations	-or-	Lab report showing positive blood titer results for measles, mumps, and rubella		
Varicella	Total of 2 vaccinations	-or-	Lab report showing positive blood titer		
Tuberculin (TB) Test	Negative results of 2 TB skin tests within the last 12 months (must be administered at least 7 days apart)	-or-	Negative results of 1 serum blood test (ex. Quantiferon, T. Spot, IGRA) within the last 12 months	-or-	Negative chest x-ray within the past five years for students who have a history of positive skin tests with written evaluation by healthcare provider for signs and symptoms within the last 12 months if x-ray is over 1 year old
Influenza	Annual seasonal influenza vaccination required in mid-fall/winter.				
Hepatitis B	Total of 3 vaccinations	-or-	Lab report showing positive blood titer	-or-	Signed Hepatitis B Vaccination Waiver
COVID	Moderna or Pfizer (2 doses total)	-or-	Johnson & Johnson (1 dose)		

I,_____(Print Name), submit this medical form (including the medical examination and health history) as being accurate and complete. I understand that falsification or inaccurate information on this form may result in dismissal from the curriculum.

Applicant's Signature_____Date _____

Student Name: **Date of Birth:** **Student ID:**

CONTACT INFORMATION (Please print in black ink) To be completed by student.

Last ↑ First Middle Maiden

Mailing Address – Street or PO Box, City, State, Zip

Student ID# Home # Work # Cell #

Forsyth Tech Student Email Address

Date of Birth Gender (Male/Female) Marital Status (Single/Married/Other)

Emergency Contact Relationship Home # Work/Cell#

PERSONAL HEALTH HISTORY (Please print in black ink) To be completed by student.

Check each item "Yes" or "No". Every item checked "Yes" must be fully explained in the space on the right (or an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, 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
Drugs, medicines, chemicals (Specify.)			
Insect bites			
Latex or other contact allergies			
	Yes	**No**	**Explanation**
Do you have any conditions or disabilities that limit your physical activities?			
Have you ever been a patient in any type of hospital?			
Has your academic career ever been interrupted due to physical or emotional problems?			
Other than for a routine check-up, have you seen a physician or healthcare professional in the past six months?			
Have you ever had any serious illnesses or injuries other than those already noted?			

IMPORTANT INFORMATION! PLEASE READ AND COMPLETE.

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT IS UNDER THE AGE OF 18):

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 or medical care.

Signature of Student (Signature of parent/guardian, if student under age 18) Date

Student Name: **Date of Birth:** **Student ID:**

IMMUNIZATION RECORD **(Please print in black ink)** **To be completed by physician.**

A complete record from physician, clinic, or health department may be attached to this form.

REQUIRED IMMUNIZATIONS	Month/Day/Year
Td booster or tDap	

	Month/Day/Year	Month/Day/Year	Titer
MMR (after first birthday)			Attach Titer Lab Report

	Month/Day/Year	Month/Day/Year	Titer
Varicella			Attach Titer Lab Report

Tuberculin (PPD) Test	#1 Date admin:		#2 Date admin:	
	Date read:		Date read:	
	mm induration:		mm induration:	
TB Serum Blood Test	Date:		Results:	
Chest x-ray, if positive PPD (must be within the past five years)	Date:		Results:	
TB Treatment, if applicable	Date:			

	Vaccine Brand	Dose 1 Month/Day/Year	Dose 2 Month/Day/Year
COVID			

	Month/Day/Year
Seasonal Influenza	

Students entering in spring semester must submit flu vaccination documentation with their medical form. Students entering in fall or summer will be given a later due date by which to submit flu vaccination documentation.

	Month/Day/Year	Month/Day/Year	Month/Day/Year	Titer
Hepatitis B series				Attach Titer Lab Report

Hepatitis B Vaccination Waiver:

Students have the right to decline the Hepatitis B vaccination after consultation with their physician on the importance of receiving the vaccination. If students decline the vaccination, they understand they may be at risk of acquiring Hepatitis B Virus (HBV) infection, and hereby release Forsyth Technical Community College from any liability related to the failure to have the immunizations. Students understand that due to the clinical experiences or lab experiences required in their curriculum, they have the potential to be exposed to blood and/or other infectious diseases.

By signing this waiver, I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

_____ _____

Student Signature Date

_____

Signature of Healthcare Provider Date

_____

Print Name of Healthcare Provider Area Code/Phone Number

_____

Office Address City State Zip Code