

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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				

### PERSONAL HEALTH HISTORY

Have you ever experienced any of the following?

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

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**

Immunization (Combined Hepatitis A and B) #1     /    /    , #2     /    /    , #3     /    /    .

Hepatitis A (**Not required**) #1     /    /    , #2     /    /    .

**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     /    /    .

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

**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,     /    /    

**OR**

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

**OR**

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

**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     

Immunization

Dose #1     /    /    

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

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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. \_\_\_\_\_

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**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.

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**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 under 18, 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".

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

# 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- $\alpha$  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 time $\alpha$
- 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 (\_\_\_\_\_) \_\_\_\_\_

