

MEDICAL HISTORY, PHYSICAL, AND IMMUNIZATION FORM

To provide the best possible medical care, we require each student to have the Medical History, Physical, and Immunization for completed by a physician, nurse practitioner, or physician's assistant.

Thaddeus Stevens College immunization requirements follow guidelines set by the American College Health Association and the Center's for Diseases and Control and Prevention. Immunization requirements may vary from state to state; we therefore recommend that your health care provider review our form carefully, assess your status, and update your immunizations as needed to fulfill our requirements.

State law requires that any individual enrolled in a Pennsylvania institution of higher education who resides in on-campus housing must be vaccinated against meningococcal disease, or must sign a waiver, which is included on the attached immunization form.

Students who fail to return their forms, or who are not in compliance with our immunization requirements, **will be notified and may delayed in starting classes.**

Upon completion of the attached forms, please return them to Thaddeus Stevens College Health Services, 750 E. King Street, Brenner Hall, Lancaster, PA 17603.

If you have any questions, please call 717-299-7769.

Thank you,

Melissa Meshey, RN

Thaddeus Stevens College

Health Services, Main Campus

Brenner Hall, 1st Floor

Phone: 717-299-7769

Fax: 717- 391-3561

MEDICAL RECORDS

Last Name	First Name	Middle Initial	Date of Birth	
Home Address	City	State	Zip	Home Phone Number
Social Security Number	email address			
Biological Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender Identity _____			

IN CASE OF EMERGENCY, NOTIFY:

Name	Relationship			
Home Address	City	State	Zip	Home Phone Number
Work Address	City	State	Zip	Work Phone Number

HISTORY

Acne	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Gallbladder D/O	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
ADD/ADHD	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Gonorrhea	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
AIDS, ARC, + HIV	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Gout	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Alcohol Problem	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Hay Fever	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Allergies	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Knee Injury	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Anemia	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Hearing Loss	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Anxiety D/O	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Heart Problems	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Asthma	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Specify _____			
Back Problems	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Heart Murmur	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Bladder Infection	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Hepatitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Bleeding trait/ sickle cell	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Herpes	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Bronchitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Hypertension	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Cancer (location) _____	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Hypoglycemia (low blood sugar)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Chlamydia	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Infectious Mononucleosis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Colitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Irritable Bowel Disease	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Concussion	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Kidney Infections/stones	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Depression	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Knee Injury	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Diabetes	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Learning Disability	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Drug Dependent	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Migraine H/a, Vascular H/a	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Eating D/o	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Obesity (more than 20lbs overweight)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Eczema	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Ovarian Cyst	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Emotional/ mental illness	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Peptic Ulcer	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Epilepsy/seizures	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Phlebitis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Eye Problem	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Pneumonia	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Specify _____				Rheumatic Fever	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Fainting	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never	Rheumatoid Arthritis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
Specify _____				Sinus Problem (Chronic)	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
				Suicide Attempt	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
				Syphilis	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never
				Thyroid Problem	<input type="checkbox"/> Current	<input type="checkbox"/> Past	<input type="checkbox"/> Never

Tension h/a Current Past Never
Tuberculosis Current Past Never
Varicella Current Past Never

Other Problems not listed (specify)

Injuries, surgeries, and hospitalizations:

Dietary Needs:

Smoking Status: Yes No # packs per day

Have you traveled outside the U.S. in the past year? Yes No
Where?

Mental Health History:

Have you ever received psychiatric counseling Yes No Currently
Have you ever been hospitalized for psychiatric care? Yes No
Have you ever been treated for an eating d/o? Yes No
Have you ever been treated for alcohol or drug dependency? Yes No

List all current prescription medications:

Medication Name	Prescribing Provider	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies?

Yes No

If "yes" please list:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you received allergy shots?

Yes No

Family History

Age Status of Health Occupation If deceased, age & cause of death

Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Are you adopted?

Yes No

You are invited to discuss your answers or any other health related issues with the Student Health Services professional staff.

The information that I have provided on this health form is accurate, to the best of my knowledge. I understand that all information is maintained as confidential within Student Health Services.

Applicants Signature

Date

PHYSICAL EXAM

To be completed by Physician:

Thaddeus Stevens College of Technology

750 E. King Street – Brenner Hall - Lancaster, PA 17603

717-299-7769 meshey@stevenscolleg.edu

717-391-3561 (fax)

Last Name First Name Middle Initial

BP _____ Heart Rate _____ Height (in.) _____ Weight (lbs) _____

Examination Findings (Describe fully. Use additional sheets if necessary)

	NL	ABN	Findings (describe)		NL	ABN	Findings (describe)
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose/Sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuro	<input type="checkbox"/>	<input type="checkbox"/>	_____

General Comments _____

Recommendations for physical activity:

Including physical education, athletic activities, sports, **essential skills r/t program of study**): Unlimited Limited

Explain _____

Is the patient now under treatment for any medical or emotional condition? Yes No

Explain _____

Practitioner's signature _____ Phone Number _____

Print Last Name _____ Date _____

Address _____ City _____ State _____ Zip _____

AUTHORIZATION FOR TREATMENT OF MINORS

If the student has not yet reached her/his 18th birthday before the beginning of the academic year for which the student is registered, the following authorization by a parent or legal guardian is required.

I hereby grant permission to TSCT to proceed with any needed medical, mental health, or minor injuries treatment for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the medical provider to contact me in the most expeditious manner possible. If said provider is unable to communicate with me, the treatment necessary for the best interest of the above named student will be given.

Signature: _____ Date _____

Printed Name: _____ Relationship to student _____

Home Phone Number: _____ Work Phone Number: _____

STUDENT IMMUNIZATION RECORD

Thaddeus Stevens College

750 E. King Street – Brenner Hall - Lancaster, PA 17603
717-299-7769 meshey@stevenscollege.edu
717-391-3561 (fax)

Last Name First Name Middle Initial

M F

Date of Birth Biological sex (circle)

MANDATORY IMMUNIZATIONS for Thaddeus Stevens College of Technology

To be completed and signed by a health care provider. (Dates must include month, day & year)

REQUIRED IMMUNIZATIONS:

M.M.R (Measles, Mumps, Rubella)

OR

M.M.R. Titer (Measles, Mumps, Rubella)

Option 1

Option 2

Dose 1 – Immunized at 1 yr or after
_____/_____/_____

Lab Report of titer _____
Copy of report must be attached

Dose 2 – At least 4 weeks after dose 1
_____/_____/_____

Tetanus – Diphtheria (TD booster within last 10 years)

TD ____/____/_____

Or

Tdap ____/____/_____

Meningococcal Vaccine Information

For individuals 18 years or older:

I am 18 years of age or older, I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of the meningococcal vaccine. I understand that meningococcal disease is rare but life-threatening illness. I understand that Pennsylvania law requires an individual enrolled in an institution of higher education in Pennsylvania who resides on campus in student housing to receive vaccination against meningococcal disease unless the individual signs a waiver.

Meningococcal Waiver

I choose to waive the meningococcal vaccine.

Signature of student (parent if under 18)

Date ____/____/_____

If vaccine has not been received, a meningococcal waiver must be signed by student/parent

or

Meningococcal Vaccine

MCV(Menactra/Menveo/Menomune)

Date ____/____/_____

Booster

(if initial dose was given before 16th birthday)

Date ____/____/_____

Bexsero/Trumenba (type B)

Date ____/____/_____

RECOMMENDED IMMUNIZATIONS:

Hepatitis B

Dose 1 ____/____/_____

Dose 2 ____/____/_____

Dose 3 ____/____/_____

Varicella

History of Disease (year) _____

or

Dose 1 ____/____/_____

Dose 2 ____/____/_____

Other: _____

Practitioner's Signature: _____ Print last name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone # _____

STUDENT IMMUNIZATION RECORD

Thaddeus Stevens College

750 E. King Street – Brenner Hall - Lancaster, PA 17603
717-299-7769 meshey@stevenscollege.edu
717-391-3561 (fax)

Student Name

Date of Birth

HEALTH INSURANCE COMPANY

Name

Policy Holder

Policy No.

Group No.

Insurance company address

City

State

Zip

Insurance company phone number

Copy of insurance card must be attached.

Dear Physician,

Each major at Thaddeus Stevens College of Technology has a significant lab component that replicates actual duties required in the workplace. Please review the following physical skills that are essential to these majors. Place circle any skill which the student may have difficulty performing. If the skill may be accommodated, provide a letter documenting how you recommend the skill be accommodated. The recommendation will be reviewed by the college. **Please sign the form to indicate that it was reviewed.**

Thank you for aiding in providing a safe working environment for our students.

Safety Sensitive Majors

Building: Cabinet making, Carpentry, Electrical, Electro-Mechanical, Masonry, Plumbing, Residential Remodeling, Career Prep class

Bending/Twisting	Crawling	Coordination
Lifting	Reaching	Climbing
Working outdoors	Working in cramped spaces	Balance
Exposure to Dust	Exposure to chemicals	Exposure to extreme temperatures
Eye Hand Coordination	Manual Dexterity	Finger Dexterity
Visual Discrimination	Near vision	Far Vision
Color Discrimination	Depth Perception	Repetitive Movements
Operating Power tools	Grasping	

Automotive: Collision Repair, Automotive

Exposure to dust	Exposure to chemicals	Grasping
Bending	Twisting	Depth perception
Crawling	Lifting	Near vision
Near vision	Color Discrimination	Hearing Sensitivity
Speech Recognition	Finger Dexterity	Manual Dexterity
Eye Hand coordination		

Metals/Machining: Machine, Metals Fabrication and Welding

Standing for extended time	Using Hazardous Equipment	
Reaching	Lifting	Grasping
Finger Dexterity	Manual Dexterity	Eye Hand coordination
Visual Discrimination	Near vision	
Repetitive movements involving fingers, hands, arms		

Heating, Ventilation & Air Conditioning/Water Environmental Technology

Walking	Bending	Twisting
Crawling	Lifting	Working in tight spaces
Exposure to chemicals	Exposure to extreme temperatures	
Work outdoors	Near Vision	Far Vision
Visual Discrimination	Color Discrimination	Speech Recognition
Depth Perception	Hearing Sensitivity	

Computer based majors: Architecture, Business Administration, Computer Aided Technology, Computer Networking, Electronics, Graphic Communications, and Mechanical Engineering

Sitting for extended time	Repetitive movements involving fingers, hands	
Grasping	Manual Dexterity	Finger Dexterity
Eye hand coordination	Visual Discrimination	Near Vision
Far Vision	Color Discrimination	Depth Perception
Speech Recognition	Speech Clarity	

My signature below indicates that these skills were reviewed and the student at this time appears able to perform the skills necessary for his/her program of study.

Physician Signature

Date