

NORTHAMPTON COMMUNITY COLLEGE

HEALTH FORM

FUNERAL SERVICE EDUCATION PROGRAM

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

PART I – REPORT OF MEDICAL HISTORY

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

Student Name: _____

Last

First

Middle

Home Address: _____

City/State/Zip: _____

Home Phone: _____

Email Address: _____

Program: **Funeral Service Education**

Semester: FA SP SU Year _____

Student ID #: _____

Gender: Male Female Other _____

Preferred: He/Him She/Her They/Them

Cell Phone: _____

Date of Birth: _____

On Campus Housing: Yes No

Campus: Main Fowler Monroe

I. EMERGENCY NOTIFICATION

Name of Contact: _____

Home Address: _____

Primary Phone: _____

Relationship: _____

City/State/ Zip: _____

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 (Required) – Student must upload a copy of current health insurance card (front and back) to myRecordTracker®. Student is required to have valid health insurance for the duration of the program, and must notify the Program Director and the Health and Wellness Center of any change in health insurance which occurs during the program, and upload a copy of the new insurance card.

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 Program Director and appropriate designee(s), to the Northampton Community College Health and Wellness Center, to the appropriate health care agency in which I am completing clinical requirements, 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 the start of the clinical experience** by a licensed medical provider (MD, DO, CRNP, or PA-C) is **required** prior to entry into clinical practice. Clinical work is **PROHIBITED** until the required medical forms are uploaded and verified.

Name: _____ Student ID: _____ DOB: _____

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 | | | <i>If positive for exposure, please submit titers.</i> |

| | |
|--------------------------------------|--|
| Allergies | |
| Medications taken on a regular basis | |

| **IMPORTANT** LICENSED PROVIDER, PLEASE INITIAL TO CERTIFY THE FOLLOWING: | INITIALS |
|---|----------|
| I certify that the applicant is free from communicable diseases in the communicable state. | |
| I certify that the applicant has no medical conditions or restrictions which will prevent the applicant from performing the essential functions of the job. (If the applicant has restrictions that require accommodation, please note them in the comments section below.) | |
| Comments <i>(if applicant has any limitations, please explain)</i> : | |

| | |
|--------------------------------------|------------|
| 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 before beginning your experience at Clinical Sites.

IMMUNIZATIONS (Vaccinations)

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

- ♣ **Hepatitis B** – 3 doses
- ♣ **TDAP** – Tetanus Diphtheria Acellular Pertussis (*Dated within 10 years*)

HEPATITIS B SURFACE ANTIBODY, QUANTITATIVE TITER

- ♣ **All Students** are required to obtain the **Hepatitis B Surface Antibody, QUANTITATIVE Titer** to determine immunity status and **UPLOAD the lab report** to myRecordTracker®. **Titer results must be dated within the past three years.**

HEPATITIS B REPEAT SERIES OR BOOSTER (*Required if titer shows no or low immunity*)

- ♣ If the Hepatitis B Surface Antibody, Quantitative Titer shows no immunity, the repeat series of three doses should be started immediately.
- ♣ If the titer shows low immunity, a booster dose should be given immediately. The repeat titer should be given one month after the booster or last dose.
- ♣ Any repeat doses, booster, and titer reports must be uploaded to myRecordTracker® each time they are received.

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.**

SUPPORTING DOCUMENTATION OPTIONS

- ♣ Immunization records can include your childhood and/or school immunization records – or a print out 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