Vermont State University

2023-2024

Student Health Form

INSTRUCTIONS

1. Schedule a physical exam appointment with a health care provider.
2. Print all pages of this form, complete pages 1 and 2, and take to your health care appointment. **A health care provider must complete and sign pages 3 and 4**.
3. Make sure all pages and signatures are complete.
4. Upload instructions will appear on your Application Status Page. **Please do not mail your completed form**.
5. Contact Healthforms@VermontState.edu with any questions.

IMPORTANT DEADLINES:

JUNE 1

Health professions students – Dental, Nursing, Paramedicine, Radiologic Science, Respiratory Therapy

AUGUST 1

All non-health professions students

JANUARY 1

Students starting classes in the spring semester

Student health form submission is required for all undergraduate students enrolled at least half-time (6 credits or more), and all health professions students. Student health forms are required for course registration and failure to submit a health form may delay registration. If your instruction is solely field work or study away from the classroom (virtual or online), you are not required to submit the health form.

International students who will attend face to face classes are also required to complete this health form. In order to avoid delays in registration, it is highly recommended that all immunization and physical exam requirements are completed prior to international travel. If immunizations are not available in your home country please reach out to Kathleen Mason, Director of International Student Services and Global Affairs, to create a plan.

GENERAL INFORMATION

Full Name _____Preferred Name: _____

Date of Birth: _____ / _____ /_____ Gender: _____ Preferred Pronoun: _____

Student ID: _____

Permanent Address: _____ City _____State _____Zip Code _____

Telephone: Home (_____)_____ Work (_____)_____ Mobile (_____)_____

EMERGENCY CONTACT

Full Name _____Relationship: _____

Permanent Address: _____ City _____State _____Zip Code _____

Telephone: Home (_____)_____ Work (_____)_____ Mobile (_____)_____

HEALTH INSURANCE (Attach copy of insurance card; front and back)

Insurance Company _____

Policy ID: _____ Group Number: _____

Insurance Subscriber: _____ Insurance Subcriber Date of Birth: _____ / _____ /_____

SIGNATURE

My signature below indicates that: I consent to medical and nursing treatment by the university health center staff; This information is correct and complete to the best of my knowledge; and I understand that my health care and mental health information is confidential, but information may be shared without additional consent in the case of an emergency.

Student Signature_____Date: _____

Parent/Guardian Signature_____Date: _____

(Required if the student is under 18 years of age, is under guardianship, or if the student's insurance is in the parent/guardian's name)

Student Medical and Family History

Student Name	**Date of Birth**

Allergies: Include intolerances and type of reaction.
Medications □ Yes □ No
Food/Environmental □ Yes □ No

Medications: List all current prescription and non-prescription medications, vitamins, minerals, supplements, hormones, and birth control pills.

Hospitalizations and Surgeries: Have you ever been admitted to the hospital for a surgical or medical condition? If yes, please list the related diagnosis and date(s). Include outpatient and surgical dental procedures as well.

Counseling and Mental Health: Have you ever received mental health counseling, substance abuse counseling, or outpatient or inpatient psychiatric care? If yes, please list the related condition(s) and date(s)

Medical History: Do you have or have you previously had any of the following? Check those that apply

□ Anemia or other blood condition	□ Ear/nose/throat problems	□ Joint or limb problem	□ Pneumonia
□ Asthma	□ Eating disorder	□ Kidney/bladder problem	□ Polio
□ ADHD	□ Eye problems	□ Marfan's syndrome	□ Seizure or epilepsy
□ Bleeding disorder	□ Fainting	□ Meningitis	□ Sickle cell disease or trait
□ Blood clot	□ Fibromyalgia	□ Menstrual problems	□ Skin problems
□ Breast abnormality	□ Headaches	□ Mental health condition	□ Stomach or intestinal problems
□ Broken bone	□ Hearing loss	□ Missing or removed organ	□ Substance abuse
□ Cancer	□ Heart problems	□ Migraines	□ Thyroid problems
□ Chickenpox	□ Hepatitis/liver disease	□ Mononucleosis	□ Tobacco use
□ Concussion or head injury	□ Hernia	□ Musculoskeletal injury	□ Tuberculosis or positive TB test
□ Counseling	□ High blood pressure	□ Oral braces	□ Underweight
□ Dental problems	□ High cholesterol	□ Orthopedic problems	□ Urinary tract infection
□ Diabetes	□ HIV/AIDS	□ Overweight	
		□ Paralysis	

Explain any "yes" check marks:

Family History
□ Unknown

Condition	**Yes**	**No**	**Relationship**	**Condition**	**Yes**	**No**	**Relationship**
Cancer; Type:				Mental Health Condition; Type:			
Diabetes				Marfan's syndrome			
Heart disease				Substance abuse			
High blood pressure				Sudden death before age of 50; Cause:			
High cholesterol				Other serious condition; Type:			
Liver disease							

If either parent or a sibling is deceased, list relationship to you, age at death, and cause of death

Family Member	Age	Cause

Comments:

Reviewed by health care provider □ Yes	Date

Athlete Screening Questions

Student Name	**Date of Birth**

FOR STUDENT ATHLETES ONLY:

1. I wish to participate in college athletics □ Yes □ No; If yes, which sport(s) _____
2. Have you ever passed out or become extremely dizzy during exercise? □ Yes □ No
3. Have you ever had chest pain during exercise? □ Yes □ No
4. Do you get tired more quickly than others when exercising? □ Yes □ No
5. Have you ever had a "racing" heart or felt like it skipped beats? □ Yes □ No
6. Did you have heart problems as a child? □ Yes □ No
7. Has a health care provider ever restricted or denied your participation in sports due to a heart problem? □ Yes □ No
8. Do you cough frequently after exercise? □ Yes □ No
9. Have you ever become ill from exercising in the heat? □ Yes □ No
10. Do you have problems with muscle cramps with exercise? □ Yes □ No

Student Physical Exam – MUST BE COMPLETED BY HEALTH CARE PROVIDER

Exam Date (must be within past 12 months)			
Height	Weight	Temp	Pulse
Resp	BP	Vision: R L	Corrected □ Yes □ No

Normal	Abnormal	System	Comments
		General growth and development	
		Head, face, scalp, skull	
		Oral cavity/teeth	
		Eyes	
		Ears, hearing	
		Nose, sinuses, throat	
		Neck, thyroid	
		Heart	
		Lungs	
		Breasts	
		Abdomen (include hernia screen)	
		GYN (if indicated)	
		Genitals (include testicular exam)	
		Rectal (if indicated)	
		Musculoskeletal	
		Lymph glands	
		Neurological	
		Skin, hair, nails	

Essential Function Screening Questions

No	Yes	
		Is this student receiving medical care for a chronic condition or serious illness that may interfere with participation in program requirements?
		Do you have concerns about this student participating in strenuous physical activity?
		Do you have concerns about this student's mental or emotional condition interfering with their ability to participate in program requirements?
		If applicable, this student is cleared to play college sports □ Without restrictions □ With the following restrictions _____ □ This student is not cleared to participate in college athletics

Comments for those marked "yes":	
Provider name (printed)	
Provider Signature	Date

Student Immunizations – MUST BE REVIEWED AND SIGNED BY HEALTH CARE PROVIDER

Student Name	**Date of Birth**

The following immunizations are required for students attending face to face classes at least half time and for all health professions students.

Vaccine	**1st dose date**	**2nd dose date OR Booster**	**3rd dose date OR Booster(s)**
MMR (Measles, Mumps, Rubella) – 2 doses			
Hepatitis B – 3 doses			
Tdap (Tetanus, diphtheria, pertussis) – 1 dose regardless of last td.			
Varicella (chickenpox) – 2 doses or history of disease (complete VT Health Department form). **Health professions students must provide titer showing immunity if not vaccinated.**			
Meningococcal – 1 or 2 doses for first year **dorm residents**. Only those vaccinated before their 16th birthday need the 2nd dose.			
COVID-19 – Health professions students must be up to date with COVID vaccination by receiving primary vaccination series and all recommended boosters.			

Tuberculosis Screening – ALL STUDENTS MUST COMPLETE	**Yes**	**No**
Has the student lived in a country where TB is common, including Latin America, the Caribbean, Africa, Asia, Eastern Europe and Russia?		
Has the student had close contact with a person who has active TB disease?		
Hast the student lived or worked in a high-risk setting such as long-term care facilities, homeless shelters or correctional facilities?		
Has the student worked with patients who have increased risk for TB?		

If YES to any of the above a Tuberculin Skin Test (TST) OR IGRA blood test is required. If positive TST or IGRA, a normal chest x-ray is required. **ALL HEALTH PROFESSION STUDENTS MUST COMPLETE REGARDLESS OF RISK LEVEL. IF YOU HAVE A TST, A 2-STEP IS REQUIRED (1st TST + 2nd TST 1-3 weeks later).**

TST #1	Date placed:	Date read:	mm induration
TST #2 (health professions students)	Date placed:	Date read:	mm induration
IGRA blood test	Date of test:	Result (attach lab report)	
Chest x-ray	Date of x-ray	Result (attach lab report)	

Provider name (printed)	
Provider Signature	Date

Practice Contact Information

Address	Phone number	Fax number