



Toccoa Falls College Medical History Form

Fields marked with * are required fields.

**YOU MUST COMPLETE MEDICAL FORMS IF YOU ARE ENROLLED FOR 6 OR MORE CREDIT HOURS ON CAMPUS.
ONLINE-ONLY STUDENTS ARE NOT REQUIRED TO COMPLETE MEDICAL FORMS.**

Please complete and return by

Mail:

Student Health Services
Toccoa Falls College
107 Kincaid Dr. MSC 787
Toccoa Falls, GA 30598

OR Fax:

706-282-6026

OR email: health@tfc.edu

Please call 706-886-7299 ext. 5304 or email health@tfc.edu with questions.

DEMOGRAPHIC INFORMATION*

Full Legal Name*: Last _____ First _____ Middle _____

Preferred First Name: _____ Email* _____

Date of Birth*: _____ Social Security #: _____
MM DD YYYY XXX XX XXXX

Home Address* _____
Number and Street

City _____ State _____ Zip Code _____

Phone Number* _____

Country _____

ENROLLMENT INFORMATION*

Gender* Male _____ Female _____

Term* Fall _____ Spring _____ Summer _____ Year* 20_____

Type of Student* New _____ Transfer _____ Readmit _____

Status* Traditional Full-time _____ Traditional Part-time _____ Dual Enrolled _____

Housing* On-Campus _____ Off-Campus _____

EMERGENCY CONTACT INFORMATION*

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

MEDICAL INSURANCE INFORMATION (if applicable)

Insurance Company _____

Insurance Company Street Address _____

City _____ State _____ Zip Code _____

Insurance Company Phone Number: _____

Country _____

Name of Insured: _____

Last

First

Middle

Insured Date of Birth: _____

MM

DD

YYYY

Policy/ID Number: _____

PERSONAL HEALTH HISTORY*

Check All That Apply

 Anemia/Blood Disease ADD/ADHD/Dyslexia Asthma/Lung Problems Cancer Depression/Anxiety/Bi-Polar Diabetes/Hypoglycemia Eating Disorder/Low Weight/Obesity Dizziness/Fainting Tuberculosis Eczema/Skin Disorder Heart Disease/Condition Headaches (recurrent) Hypertension Hepatitis/Liver Disorder Musculoskeletal Disorder Kidney/Urinary Problems Stomach Trouble/GI Issues Neurological Disorder/Seizures Vision or Hearing Problems Thyroid Disorder Other

If any apply, please explain:

ALLERGIES*

Drug Allergies* Yes No If yes, please explain: _____

Non Drug Allergies* Yes No If yes, please explain: _____

Do you carry an EpiPen?* Yes No

PRESCRIPTIONS AND MEDICATIONS*

Do you take prescription medicine?* Yes No If yes, please explain: _____

Do you take any NON-prescription medication on a regular basis?* Yes No

If yes, please explain: _____

FAMILY HEALTH HISTORY*

Check all that apply to your immediate family (parents, siblings, grandparents).

Asthma/Lung Problems

Blood Disorder/Anemia

Cancer

Cardiac Disease

Diabetes

Hypertension

Liver Disorder/Hepatitis

Migraine Headaches

Psychiatric Disorder

Seizure Disorder

Tuberculosis

Other

If yes, please explain relationship:

IMMUNIZATION HISTORY*

The following immunizations are required for admission to Toccoa Falls College if you are taking 6 or more credits per semester on-campus.

- Hepatitis B x 3 doses
- MMR x 2 doses
- Primary Series and Td or Tdap within the last 10 years
- Varicella (Chicken Pox) x 2 doses
- Meningitis Vaccine or signed Waiver

I am a Georgia resident or received many of my immunizations while living in Georgia *

Yes No If no, please complete the following required immunization information.

HEPATITIS B*

Three doses are required or alternatives/exceptions as noted.

Hepatitis B (#1) / /
MM DD YYYY

Hepatitis B (#2) / /
MM DD YYYY

Hepatitis B (#3) / /
MM DD YYYY

OR Hepatitis B Immunity

Laboratory Proof of Hepatitis B Immunity. Please attach verification.

MEASLES, MUMPS, RUBELLA (MMR)*

Two doses are required or alternatives/exceptions as noted.

MMR (#1) / /
MM DD YYYY

MMR (#2) / /
MM DD YYYY

OR Measles, Mumps, Rubella Immunity

Laboratory proof of MMR Immunity. Please attach verification.

TETANUS, DIPHTHERIA, PERTUSSIS (DPT)*

Primary Series

Dose #1 / /
MM DD YYYY

Dose #2 / /
MM DD YYYY

Dose #3 / /
MM DD YYYY

Dose #4 / /
 MM DD YYYY

Dose #5 / /
 MM DD YYYY

***TETANUS (Td or Tdap) booster dose within the last 10 years** / /
 MM DD YYYY

VARICELLA (CHICKEN POX)*

Two doses are required or alternatives/exceptions as noted.

Varicella Immunization Dose #1 / /
 MM DD YYYY

Varicella Immunization Dose #2 / /
 MM DD YYYY

OR History of Chicken Pox illness. Please indicate approximate date. / /
 MM DD YYYY

OR Varicella Immunity

 Laboratory Proof of Varicella Immunity. Please submit documentation.

OR Birth before 1980.

 Birth before 1980

MENINGITIS*

Please complete dates of vaccine doses (1 dose must be completed after age 16) **OR** complete Meningitis Waiver. (Meningitis Vaccine is not required but is strongly recommended especially for students living on campus.)

Meningitis Dose #1 / /
 Menactra, Menomune, or Menveo MM DD YYYY

Meningitis Dose #2 / /
 Menactra, Menomune, or Menveo MM DD YYYY

OR Meningitis Vaccine Waiver

 By signing the Meningitis Vaccine Waiver I am indicating my understanding of the risks of Meningitis and desire to waiver being protected against Meningitis. (Please attach Meningitis waiver. Meningitis waiver can be found at <http://tfc.edu/wp-content/uploads/2018/06/Meningitis-Waiver-2018.pdf> or obtained from the Student Wellness Center.)

TUBERCULOSIS SCREENING QUESTIONS – REQUIRED*

TUBERCULOSIS is an illness in which TB bacteria are multiplying and attacking a part of the body, usually the lungs. The symptoms of TB disease include weakness, weight loss, fever, no appetite, chills and sweating at night. Other symptoms of TB disease depend on where in the body the bacteria are growing. If TB disease is in the lungs, the symptoms may include a bad cough, pain in the chest or coughing up blood. A person with TB disease may be infectious and spread TB bacteria to others. (CDC, March 21, 2016)

Tuberculosis Screening Testing

Tuberculin Skin Testing or Blood Testing is only required of students who fit one of the two categories for high risk listed below. Read the information on the two categories and then indicate whether you are a student who requires testing.

Category 1:

Students who have arrived in the U.S. within the past five years from countries where TB is endemic are at risk for tuberculosis. TB is endemic in all countries except the following: USA, American Samoa, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Jamaica, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, San Marino, Sweden, Switzerland, United Kingdom and US Virgin Islands.

This applies to me*: **Yes** _____ **No** _____

Category 2:

Students who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy, and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy or HIV infections or other immunosuppressive disorders.

This applies to me*: **Yes** _____ **No** _____

Category 3:

I have received BCG (Bacillus Calmette-Guerin) Vaccine.

This applies to me*: **Yes** _____ **No** _____

If you answered YES to any of the above questions*:

Please make arrangements to obtain a Tuberculosis Screening Test unless you have received BCG. Either a PPD (skin test) or Quantiferon (blood test) are appropriate. If either test is positive or you have received BCG, a follow up chest x-ray must be performed. Please submit test and/or chest x-ray results to Student Health Services.

REMEMBER: TUBERCULOSIS IS A CONTAGIOUS ILLNESS. YOUR HONEST ANSWERS ARE IMPORTANT TO YOUR HEALTH AND THE HEALTH OF OTHERS.

CERTIFICATION STATEMENT*

By signing my name below I certify that all the information provided on this form 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 Student 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 complete and submit the separate Athletic Health and Medical Compliance Packet before I will be allowed to begin conditioning, practice or competition.

Applicant Signature* _____ Date _____

Rev. 1/20 DR