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

_____ Asthma/Lung Problems

_____ Depression/Anxiety/Bi-Polar

_____ Eating Disorder/Low Weight/Obesity

_____ Tuberculosis

_____ Heart Disease/Condition

_____ Hypertension

_____ Musculoskeletal Disorder

_____ Stomach Trouble/GI Issues

_____ Vision or Hearing Problems

_____ Other

_____ ADD/ADHD/Dyslexia

_____ Cancer

_____ Diabetes/Hypoglycemia

_____ Dizziness/Fainting

_____ Eczema/Skin Disorder

_____ Headaches (recurrent)

_____ Hepatitis/Liver Disorder

_____ Kidney/Urinary Problems

_____ Neurological Disorder/Seizures

_____ Thyroid Disorder

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 <u>required</u> for admission to Toccoa Falls College if you are taking 6 or more credits per semester on-campus.

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

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.

<u>HEPATITIS B*</u>

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.

<u>MEASLES, MUMPS, RUBELLA (MMR)*</u>

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.

<u>TETANUS, DIPTHERIA, PERTUSSIS (DPT)*</u>

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