FTCC


**Fayetteville Technical Community College**

**Tony Rand Student Center**

**Admissions Office**

**P.O. Box 35236**

**Fayetteville, NC 28303-0236**

**(910) 678-8473**

**admissions@faytechcc.edu**

**Complete and return with International Packet:**

**PRE-ENTRANCE MEDICAL RECORD**

**International Student**

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| **GUIDELINES FOR COMPLETING IMMUNIZATION RECORD FOR INTERNATIONAL STUDENTS** |

**IMPORTANT**

* Records must be documented in black INK and all corrections must be signed.
* All dates must include month, day and year of administration.
* Immunizations required for the appropriate age group as outlined below must be documented in “SECTION A” of the Pre-Entrance Medical Record provided by the educational institution.
* For International Students in a Health Profession Program, follow the Health Profession Programs Immunization Guidelines.

##### Immunizations that are REQUIRED Pursuant to NC State Law:

**Students 17 years of age or younger…………………………..……REQUIRED:**

* 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses;

one TD booster must have been within the past 10 years.

* 3 Polio (oral) doses
* 2 Measles (Rubeola), 1 Mumps, 1 Rubella (MMR is preferred vaccine) or positive blood titers for Measles, Mumps and Rubella.
* Tuberculin skin test with negative result within the 12 months preceding the first day of classes (chest x-ray with negative result required if skin test positive, or documentation of Tuberculosis vaccination.)

**Students 18 years of age and older…………………………....…..REQUIRED:**

* 3 DTP (Diphtheria, Tetanus, Pertussis) or TD (Tetanus, Diphtheria) doses; one

TD booster must have been within the past 10 years.

* 2 Measles (Rubeola), 1 Mumps, 1 Rubella (MMR is preferred vaccine) or positive blood titers for Measles, Mumps and Rubella.
* Tuberculin skin test with negative result within the 12 months preceding the first day of classes (chest x-ray with negative result required if skin test positive, or documentation of Tuberculosis vaccination.)

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| **PHYSICAL EXAMINATION (Please type or print in black ink—no white out)** | | | | | | | | | | |
| **(A physical exam is required for both Health Profession Program and International students.)** | | | | | | | | | | |
|  | | | |  | | |  | | | |
| **Last Name First Name Middle Name** | | | | **Date of Birth (mo./day/year)** | | | **Student ID Number** | | | |
|  | | | | | | | | | | |
|  | | | | | | |  | | | |
| **Permanent Address City State Zip Code** | | | | | | | **Area Code/Phone Number** | | | |
| **Height** |  | **Weight** |  | | **TPR** |  | | **B/P** |  | / |

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| **VISION** | **Corrected Right 20/** |  | **Left 20/** |  | **Uncorrected Right 20/** |  | **Left 20/** |  |  |
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| **SYSTEMS REVIEW** | | | |
| **Are there abnormalities? If so, describe fully** | **YES** | **NO** | **DESCRIPTION (attach additional sheets if necessary)** |
| **1.**  **Head, Ears, Nose, Throat** |  |  |  |
| **2. Eyes** |  |  |  |
| **3. Respiratory** |  |  |  |
| **4. Cardiovascular** |  |  |  |
| **5. Gastrointestinal** |  |  |  |
| **6. Hernia** |  |  |  |
| **7. Metabolic/Endocrine** |  |  |  |
| **8. Musculoskeletal** |  |  |  |
| **9. Neuropsychiatric** |  |  |  |
| **10. Skin** |  |  |  |
| **11. Mammary** |  |  |  |

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| 1. **Is there loss or seriously impaired function of any paired organs?** | | **Yes** | **No** |  |
| **Explain** |  | | | |
| 1. **Is student under treatment for any medical or emotional condition?** | | **Yes** | **No** |  |
| **Explain** |  | | | |
| 1. **Recommendation for physical activity (physical education, intramurals, etc.)** | | **Unlimited** | **Limited** |  |
| **Explain** |  | | | |
| 1. **Is student physically and emotionally healthy?** | | **Yes** | **No** |  |
| **Explain** |  | | | |

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| **Only For Students Admitted to a Health Profession Program– Must Be Completed by Physician, PA or NP** | | | | | |
| **Based on my assessment of this student’s physical and emotional health on** | | |  | **, he/she appears** | |
| **able to participate in the activities of a health profession in a clinical setting.** | | **Yes  No** | | **If no, please explain** | |
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| **Signature of Physician/Physician Assistant/Nurse Practitioner** |  | **Date** |
|  |  |  |
| **Print Name of Physician/Physician Assistant/Nurse Practitioner** |  |  |
|  |  |  |
| **Office Address** |  | **Area Code/Phone Number** |

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| **IMMUNIZATION RECORD (Please type or print in black ink– no white out)** | | | | | | | | | | | | | | | |
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|  | |  | | | | |  | |  | | | | |  | |
| **Last Name** | | **First Name** | | | | | **Middle Name** | | **Date of Birth (mo./day/year)** | | | | | **Student ID Number** | |
|  | | | | | | | | | | | | | | | |
| **SECTION A** |  | | | | **Required Immunizations For All Health Profession Program Students**  ***(See Enclosure “Guidelines For Completing Immunization Record For Health Profession Program Students to determine immunizations required for the student’s age.)*** | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | **mo./day/year** | | **mo./day/year** | | **mo./day/year** | | | **mo./day/year** |
| **• DPT or Td** | | | | | | | | **#1** | | **#2** | | **#3** | | | **#4** |
| **• Td Booster** | | | | | | | |  | |  | |  | | |  |
| **• Tdap (if no tetanus immunization within the last 2 years)** | | | | | | | |  | |  | |  | | |  |
| **• Polio** | | | | | | | |  | |  | |  | | |  |
| **• Measles (MMR)**  (Rubeola, Red Measles) | | | | | | | |  | |  | |  | | | **Titer Date and Result** |
| **• Mumps (MMR)** | | | | | | | |  | |  | |  | | | **Titer Date and Result** |
| **• Rubella (MMR)**  (German Measles) | | | | | | | |  | |  | |  | | | **Titer Date and Result** |
| **• Tuberculin Skin Test (Within 30 days) Date Placed:** | | | | | | | |  | |  | |  | | |  |
| **Date Read:** | | | | | | | |  | |  | |  | | |  |
| **mm of Induration:** | | | | | | | |  | |  | |  | | |  |
| **Chest x-ray, if positive TB Skin Test Date:** | | | | | | | |  | |  | |  | | |  |
| **Results:** | | | | | | | |  | |  | |  | | |  |
| **Written TB Screening, if positive TB Skin Test Date:** | | | | | | | |  | |  | |  | | |  |
| **(CXR and Written TB Screening required if positive TB Skin Test) Results:** | | | | | | | |  | |  | |  | | |  |
| **• Hepatitis B Series** | | | | | | | |  | |  | |  | | | **Titer Date and Result** |
| **• Varicella**  (Chickenpox) | | | | | | | |  | |  | | ***Date of disease is not***  ***sufficient for proof of***  ***immunity.*** | | | **Titer Date and Result** |
|  | | | | | | | | | | | | | | | |
| **SECTION B** | | |  | **Required Immunizations For All International Students** | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **See enclosed “Guidelines For Completing Immunization Record For International Students” to**  **determine what immunizations are required for the student’s age. Document required**  **immunizations, titers, x-rays and/or screenings in “Section A” above.** | | | | | | | | | | | | | | | |
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| **SECTION C** | | |  | **Clinician Information** | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Clinician Signature or Clinic Stamp** | | | | | |  | | | | | **Telephone** | |  | | |
| **Office Address** |  | | | | | | | | | | **Date** | |  | | |
|  | | |  | | | | | | | |  | |  | | |
| **Do Not Write In This Space** | | | | | | | | | | | | | | | |

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| **Report of Medical History (Please type or print in black ink)** | | | | | | | | | | | |
|  |  | | | | |  | |  | | | |
| Last Name | First Name | | | | | Middle Name | | Student ID # | | | |
|  | | |  | | | | |  | | | |
| Permanent Address City, State, Zip Code (Area Code) Phone Number | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Date of Birth (mo/day/year) | |  | | | Gender | | Male  Female | | | Marital Status |  |
|  | | | |  | | | | |  | | |
| Name of Person to Contact in Case of Emergency | | | | Relationship | | | | | Area Code/Phone Number | | |
|  | | | |  | | | | |  | | |
| Address of Emergency Contact | | | | City, State | | | | | Zip Code | | |

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| **Important Information – Please Read and Complete** |

**STATEMENT BY STUDENT:** I have personally supplied the above and enclosed information and attest that it is true and complete to the best of my knowledge. I understand that though the information will be treated as strictly confidential, it may be released, only as appropriate and necessary to satisfy the requirements of clinical facilities where I am assigned to participate in clinical rotation. I hereby give consent for Fayetteville Technical Community College and representatives thereof to release any contents of this health/immunization record strictly for the purpose of satisfying the above mentioned clinical facility requirements. I also consent to the release of this information to faculty members within my academic curriculum for the purpose of meeting my educational requirements. No other releases are allowed without my expressed written consent.

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Signature of Student or Student’s Legal Guardian if Student is a Minor Date