



# North Country Community College

## Health Report

Name: \_\_\_\_\_  
Last Name

This health report and physician's evaluation form the basis of the employee's and student's health record for specialized cu  
This information is strictly confidential, and in no way influences the student's or employee's standing at the College.

### **NURSING STUDENTS/ FACULTY**

are required to have an annual physical examination including Tuberculin Skin Test (PPD) and must complete the "Nursing" student section of this health report.

### **RADIOLOGIC TECHNOLOGY STUDENTS/FACULTY**

are required to have an annual physical examination including Tube Skin Test (PPD) and must complete the "Radiologic Technology" se of this health report.

### **WILDERNESS RECREATION LEADERSHIP STUDENTS/FACULTY**

**are required to have an annual physical examination and must complete additional health forms.**

### **ATHLETES**

are required to have an annual physical examination and must complete additional health forms.

First Name

M.I.

***New York State Public Health Law, Section 2165, requires proof of immunity to measles, mumps and rubel proof or declination of the meningitis vaccination. This law is mandatory for ALL college students born i or later and registered for six (6) credit hours or more. (See separate Student Immunization Record Form,***

**Information recorded on this form is confidential.**

**→ PHYSICIANS: Complete Part III and sign by the bold arrows.**

**Return completed Health Evaluation in "Confidential Envelope"  
at least four (4) weeks prior to the start of classes to:**

**NORTH COUNTRY COMMUNITY COLLEGE**  
Records Office  
23 Santanoni Ave., P.O. Box 89  
Saranac Lake, NY 12983  
518-891-2915, Extension 689

**CONFIDENTIAL I. PERSONAL HEALTH REPORT CONFIDENTIAL**

To be completed by Student/Faculty

Year \_\_\_\_\_  Fall  Spring Date of Birth: \_\_\_\_\_  
 Name \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 # & Street City State Zip

Address while attending NCCC (if same as above, write "SAME"):  
 # & Street City State Zip

**Person to Notify in Case of Emergency:**  
 Address \_\_\_\_\_ Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 # & Street City State Zip

Family Physician: (If none please write in none) \_\_\_\_\_ Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Physician's Address: \_\_\_\_\_ # & Street City State Zip

**CONFIDENTIAL II. PERSONAL HISTORY CONFIDENTIAL**

Place an "X" in the appropriate box (es):

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Allergies                                      | <input type="checkbox"/> Depression  | <input type="checkbox"/> IBS  | <input type="checkbox"/> Sinusitis                    |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Diarrhea (recurrent)  | <input type="checkbox"/> Immune System Disorder                       | <input type="checkbox"/> Sore Throat (frequent)       |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Difficulty urinating/burning or pain on urination/frequency in urinating. | <input type="checkbox"/> Joint disease (injury)                       | <input type="checkbox"/> Thyroid trouble              |
| <input type="checkbox"/> Arthritis                                      | <input type="checkbox"/> Digestive Problems  | <input type="checkbox"/> pain } w/o injury                            | <input type="checkbox"/> Traumatic Brain Injury       |
| <input type="checkbox"/> Asthma/shortness of breath                     | <input type="checkbox"/> Dizziness/Fainting  | <input type="checkbox"/> swelling }                                   | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Back Problems                                  | <input type="checkbox"/> Ear Trouble   | <input type="checkbox"/> stiffness }                                  | <input type="checkbox"/> Ulcerative Colitis / Crohn's |
| <input type="checkbox"/> Bleeding Disorders                             | <input type="checkbox"/> Eye Trouble   | <input type="checkbox"/> Kidney Disease                               | <input type="checkbox"/> Other (specify): _____       |
| <input type="checkbox"/> High blood pressure                            | <input type="checkbox"/> Glasses   | <input type="checkbox"/> Infection                                    | _____   |
| <input type="checkbox"/> Low blood pressure                             | <input type="checkbox"/> Contact Lenses  | <input type="checkbox"/> Stones                                       | _____   |
| <input type="checkbox"/> Bowel Problems                                 | <input type="checkbox"/> Food Intolerances   | <input type="checkbox"/> Kidney Disorder                              |   |
| <input type="checkbox"/> Broken bones/joint dislocations                | <input type="checkbox"/> Frequent nausea or vomiting   | <input type="checkbox"/> Liver Disorder                               |   |
| <input type="checkbox"/> Chest pains on exertion or deep breathing      | <input type="checkbox"/> Headaches/ migraines (recurrent)  | <input type="checkbox"/> Mental Illness or disorder                   |   |
| <input type="checkbox"/> Chronic cough/bronchitis/ bloody sputum        | <input type="checkbox"/> Hearing Problems  | <input type="checkbox"/> Motion Sickness                              |   |
| <input type="checkbox"/> Chronic pain in                                | <input type="checkbox"/> Hearing aid   | <input type="checkbox"/> Pneumonia                                    |   |
| <input type="checkbox"/> neck <input type="checkbox"/> arms             | <input type="checkbox"/> Heart Defect/Disease  | <input type="checkbox"/> Problems w/ teeth                            |   |
| <input type="checkbox"/> back <input type="checkbox"/> legs             | <input type="checkbox"/> Heartburn/GERD  | <input type="checkbox"/> dentures                                     |   |
| <input type="checkbox"/> shoulders <input type="checkbox"/> other       | <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> bridge                                       |   |
| <input type="checkbox"/> Chronic skin problems (rash, infection)        | <input type="checkbox"/> Hernia  | <input type="checkbox"/> Serious sprains/weakness of muscles          |   |
| <input type="checkbox"/> Concussion (within last yr)                    | <input type="checkbox"/> History of diabetes   | <input type="checkbox"/> Seizures                                     |   |
| <input type="checkbox"/> Continuing use of alcohol, drugs, or medicines |  | <input type="checkbox"/> Severe injury to head/ chest/internal organs |   |
|   |  | <input type="checkbox"/> Severe menstrual cramps/bleeding             |   |

If checked any of the above, please explain below. Be specific. Use additional paper if necessary.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any allergies to foods, drugs, etc. \_\_\_\_\_

Do you take any medications regularly?  Yes  No If "Yes", please list drug(s) and dosage(s) \_\_\_\_\_

Please list any serious injuries, illnesses, fractures, dislocations and surgery: \_\_\_\_\_

Do you have any disability or impairment of which we should be aware? Yes No

If "Yes", please explain: \_\_\_\_\_  
\_\_\_\_\_

Are you currently receiving treatment at a clinic or by a physician (other than regular checkups)? Yes No

If "Yes", please explain: \_\_\_\_\_  
\_\_\_\_\_

Are you or have you ever been under the care of a psychologist, psychiatrist or psychiatric clinic? Yes No

If "Yes", please explain: \_\_\_\_\_  
\_\_\_\_\_

When was your last tetanus booster? \_\_\_\_\_  
\_\_\_\_\_

**RELEASE AUTHORIZATION**  
**NURSING and RADIOLOGIC TECHNOLOGY STUDENTS / FACULTY ONLY** **CONFIDENTIAL**

I affirm that I have completed Sections I and II of the Health Report completely and accurately. By signing this form, I hereby authorize NCCC to disclose, as needed, any and all of my health-related records to: clinical and community facilities and agencies that I will be assigned to; College program faculty, staff and administrators who have legitimate educational interest in this information; and emergency and other medical personnel in a medical or medical emergency situation. I also assume full responsibility for my participation in clinical and community experiences, releasing the College from any and all liability. I further understand that if at any time during the semester my health conditions change or I am involved in an accident that affects my ability to provide care, I will notify NCCC Records Office immediately.

\_\_\_\_\_  
Name (Please Print) Student / Faculty Signature Date

**Physician's Evaluation**  
*Please print or type all information. Thank you.*

**CONFIDENTIAL** **III. PHYSICAL EXAMINATION** **CONFIDENTIAL**

**A. NURSING and RADIOLOGIC TECHNOLOGY STUDENTS / FACULTY ONLY** **CONFIDENTIAL**

1. Tuberculin Skin Test (PPD) every 12 months. Date: Administered \_\_\_\_\_

Date Read \_\_\_\_\_ Results \_\_\_\_\_

(Must be read in mm induration, not simply as negative or positive)

➔ **SIGNATURE AND TITLE OF HEALTH CARE PROFESSIONAL READING THE PPD (MANTOUX):**

\_\_\_\_\_  
Signature/Title Date Name (please print)  
Address \_\_\_\_\_  
Phone Number (with area code) \_\_\_\_\_

If positive, a chest x-ray must be provided Date: \_\_\_\_\_ Results: \_\_\_\_\_

Did patient have treatment for the positive skin test? Yes No

Drug: \_\_\_\_\_ Date started: \_\_\_\_\_ Date completed: \_\_\_\_\_

**B. FOR ALL APPLICANTS****CONFIDENTIAL**

PHYSICIANS: Please complete **ALL** sections of this form. **It cannot be accepted unless completed.**

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:	Blood Pressure:
Lab tests at Physician's discretion:	Hemoglobin or Hematocrit:	Urinalysis:	Other:

CLINICAL EXAMINATION Check each item in proper column.	NORMAL	ABNORMAL	NOTE: Give details of each abnormality. Enter N.E. if not evaluated.
Metabolic Endocrine System			
Musculoskeletal System			
Neuropsychiatric System			
Abdomen / Pelvic			
Respiratory			
Cardiovascular System			
Gastrointestinal System			
Head			
Neck			
Eyes			
Ears			
Nose			
Throat & Teeth			
Breasts			
Genito-Urinary			
Extremities			
Skin			

Is this student able to participate in all physical activity to include one or more of the following: Clinical Hospital Experience, Extended Wilderness Trips and Camping Experiences, Physical Education, Intramural or Intercollegiate Sports Competition.

Yes  No If "No" what activities are to be eliminated?

---

Is there (or has there ever been) evidence of anxiety or emotional instability?

Yes  No If so, please indicate how the College may be of help to this student.

---


After considering the history and physical examination, what is your professional opinion of this applicant's ability to meet the physical and emotional demands of college life?

---

Do you recommend further investigation or treatment?

Yes  No If "Yes" please explain.

---

NAME OF EXAMINING PHYSICIAN (PLEASE PRINT)		PHONE	
STREET	CITY	STATE	ZIP
 SIGNATURE			DATE