North Country Community College

PHYSICAL HEALTH REPORT

This health report and physician's evaluation form the basis of the employee's and student's health record for specialized curricula. 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 Tuberculin Skin Test (PPD) and must complete the "Radiologic Technology" section 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.

New York State Public Health Law, Section 2165, requires proof of immunity to measles, mumps and rubella and proof or declination of the meningitis vaccination. This law is mandatory for ALL college students born in 1957 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"

NORTH COUNTRY COMMUNITY COLLEGE
ATTN: JIM CUNNINGHAM, WRL
PO BOX 89
SARANAC LAKE NY 12983
(518) 891-2195, Ext. 1223

Name: _____, _____, _____
Last Name First Name M.I.

CONFIDENTIAL — I. PERSONAL HEALTH REPORT — CONFIDENTIAL

To be completed by Student/Faculty

Year_____ ☐ Fall ☐ Spring Date of Birth: _____

Name _____

Home Phone E-mail Address

Home 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:

_____

Day Phone Evening Phone Relationship

Address _____

& 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):

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

_____

_____

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

Name of student: _____ Date of Birth: _____ (mm/dd/yyyy)

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

Sex: ☐Male ☐Female	Height:	Weight:	Blood Pressure:

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			

RECOMMENDED:

Lab tests at Physician's discretion:	*Hemoglobin or Hematocrit:*	*Urinalysis:*	*Other:*

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	

Name:_____

Wilderness Recreation Leadership Students/Faculty Only
TO BE COMPLETED BY DOCTOR

Participation in WRL field experiences is not an appropriate choice for individuals dealing with motivational, behavioral or rehabilitation issues. NCCC reserves the right to deny a student admission into any WRLP field activity if it is determined the student is unable to meet the physical, mental, social or safety demands of the activity.

I. Certain medical or psychological conditions may be determined as contraindicative to participation in Wilderness Recreation field activities. **(TO BE FILLED OUT BY THE DOCTOR).**

Please check if student has history of the following:

☐ Any condition or illness that could become immediately life threatening in a backcountry situation where medical assistance may be hours or miles away.
Explanation:

☐ Any physical limitation that may put the student at risk for injury or endanger the welfare of the group.
Explanation:

☐ Any psychological condition that may affect the personal safety of the student or the group as a whole.
Explanation:

By not checking any items above, I affirm that the student does not have any of the types of conditions listed above.

➔Physician's Signature_____ Date: _____
(Required for Section I)

II. During Wilderness Recreation Leadership field activities, students must be able to meet the following physical requirements. To the best of your knowledge, do you feel the student is capable of meeting the physical requirements listed below in their present medical condition? **(TO BE FILLED OUT BY THE DOCTOR).**

Does the student have to ability to:

☐Yes ☐No 1. Independently lift and carry equipment and supplies weighing up to 90 pounds including, but not limited to, backpacks, loaded duffle bags and safety equipment.

☐Yes ☐No 2. Lift and carry the following items as part of a team: canoes and rescue litters.

☐Yes ☐No 3. Sit, kneel, and stand in order to attend outdoor classes and complete camp tasks.

☐Yes ☐No 4. Right an overturned canoe as part of a team , and independently re-enter the boat from the water.

☐Yes ☐No 5. Hike with a loaded backpack for distance as long as 10 miles, on all types of terrain including rocky and steep areas.

☐Yes ☐No 6. Withstand extreme environmental conditions including but not limited to rain, snow, and extreme temperatures.

If checked NO, please explain: _____

_____

_____

I affirm by signing below that the student has the ability to complete all tasks in Section II unless otherwise indicated.

➔Physician's Signature_____ Date:_____
(Required for Section II)

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