CONNECTICUT TECHNICAL EDUCATION AND CAREER SYSTEM

Full-Time Adult Education Student Acceptance Package

Phase II

Note: The following form is not to be completed and returned unless you are accepted into a program.

Connecticut Technical Education and Career System
ADULT MEDICAL INFORMATION FORM
COMPLETE AND RETURN TO:

_____

School Name and Address

STUDENT'S NAME: _____
Last **First** **M.I.**

ADDRESS: _____
Street **City** **State** **Zip**

PHONE: _____ **CELL PHONE:** _____ **WORK:** _____

EMERGENCY NUMBER: _____ **CONTACT PERSON:** _____

TRADE/PROGRAM: _____ **DATE OF BIRTH:** _____

Part I: Immunization History:

To the Healthcare Provider. Please complete and sign below.

Vaccine Type	Immunization	Date
Tdap/TD		
Oral Polio/IPV		
MMR		
Varicella		
Hepatitis B/Hepatitis B surface & Cor Ab test		

Disease HX of above _____ _____ _____
(Specify) (Date) (confirmed by)

Exemption: Religious _____ Date _____ Medical _____ Date _____

TB: High-Risk Group: PPD data read: _____ Results: _____ Treatment: _____

Quantiferon Blood Test: Date _____ Results: _____ Treatment: _____

I certify that is applicant has the immunizations required.

Signature _____ Date: _____
Signature of Healthcare Provider MD/DO/APRN/PA

TO BE COMPLETED BY PHYSICIAN

_____ has had a complete history and physical examination on _____

Findings are indicated as follows:

CBC/ Urinalysis_____ Blood Pressure_____ Height_____ Weight_____

Vision Right _____ Left_____ Type Of Test _____

Right _____ Left _____ No Glasses _____

With Glasses _____

Auditory Right_____ Left_____

Other Test Data Result Referral

_____

_____

_____ The applicant has the following conditions, which may adversely affect his/ her performance:

Visual _____ Emotional or Social _____
Hearing _____ Other _____
Physical Illness or Impairment _____

COMMENTS AND/OR RECOMMENDATIONS:

_____ The applicant has a health condition which may require emergency action while at school. (Please specify below –e.g. seizures, bee sting allergy, other allergy, diabetes, etc.)

_____

_____

The applicant is on long-term medication. (Please specify below.)

_____

_____

Physician's Name (Printed) _____ Phone _____

Signature _____ Date _____

Acceptable signature: Physician, Physician's Assistant or an APRN

REFUSAL FOR USE OF HEPATITIS B VIRUS VACCINE

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this hepatitis B vaccination at this time, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can then receive the vaccination series.

NAME: _____ DATE: _____

WITNESS: _____ DATE: _____