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.

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Immunization</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap/TD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Polio/IPV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B/Hepatitis B surface &amp; Cor Ab test</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
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: ________________