SOUTHERN COLLEGE

STUDENT MEDICAL FORM

Return To: Southern College
Office of Admissions
Soldier Road
Nassau, Bahamas

Apply Online: sc.edu.bs/Admissions

ENSURE **ALL** PARTS OF THIS FORM ARE COMPLETED BEFORE SUBMITTING. **PLEASE PRINT LEGIBLY**

PART 1: Personal Information – TO BE COMPLETED BY ALL STUDENTS

Last Name:	Frist Name:	Student ID#:
Local Address:		
City:	**Country:**	**P.O.Box:**
Date of Birth (mm/dd/yyyy):	**Cell Phone:**	**Daytime Phone:**
Marital Status: [ ] Single [ ] Married [ ] Divorced		

PART 2: Emergency Contact Information – TO BE COMPLETED BY ALL STUDENTS

In the event of an emergency, I give Southern College permission to contact :

Name: _____ **Relationship:** _____

Cell Phone: _____ **Daytime Phone:** _____

PART 2a: Minor Consent – ONLY IF STUDENT IS UNDER 18 YEARS AT THE TIME OF ENROLLMENT

Parental permission or the consent of a legal guardian must be obtained to provide medical care to minors. To avoid delays in treatment in the event of illness or accident, please obtain the signature of a parent/legal guardian if you are under 18 years of age at the time of enrollment.

I hereby authorize the Healthcare staff of Southern College's to assess, test, administer vaccines, and if necessary, treat my minor or dependent.

Signature of Parent or Guardian: _____ **Date:** _____

Printed Name of Parent or Guardian: _____ **Relationship:** _____

_____ _____

Applicant's Signature Date (mm/dd/yyyy)

PART 3: Tuberculosis Screening – TO BE COMPLETED BY ALL STUDENTS

The following tuberculosis (TB) screening questions are required for ALL students. Refer to below list of countries for Questions 1 and 2.

1. Were you born in a country where tuberculosis is endemic AND did you arrive in The Bahamas within the last 5 years? [ ]Yes [ ]No

2. Have you traveled in countries where tuberculosis is endemic for **3 consecutive months** or more **within the last 5 years**? [ ]Yes [ ]No

3. Have you had close contact with anyone who is/was sick with tuberculosis? [ ]Yes [ ]No

4. Do you have any medical conditions such as chronic renal failure, leukemia, or lymphoma, HIV infection or any other immunosuppressive disorder? [ ]Yes [ ]No

5. Do you have any symptoms of active tuberculosis such as: cough lasting 3+ weeks, night sweats, fever, unexplained weight loss and fatigue? [ ]Yes [ ]No

6. Have you resided in, volunteered, or worked in a high-risk setting such as prisons, nursing homes, hospitals, or homeless shelters? [ ]Yes [ ]No

_____ _____

Healthcare Provider Name **Healthcare Provider Signature**

If answers to ALL the above questions are NO, no TB testing or chest x-ray is required; go to part 5.
If the answer is YES to ANY of the above questions, Southern College requires your healthcare provider to complete Part 4 on the next page (tuberculosis test).

Afghanistan	Croatia	Kazakhstan	Nepal	South Africa
Algeria	Democratic	Kenya	Nicaragua	Sri Lanka
Angola	People's	Kirabati	Niger	Sudan
Argentina	Republic of Korea	Kuwait	Nigeria	Suriname
Armenia	Democratic	Kyrgyzstan	Pakistan	Swaziland
Azerbaijan	Republic	Lao People's Democratic	Palau	Syrian Arab Republic
Bahrain	of the Congo	Republic	Panama	Tajikistan
Bangladesh	Djibouti	Latvia	Papua New Guinea	Thailand
Belarus	Dominican	Lesoto	Paraguay	The Former Yugoslav Republic of
Belize	Republic	Liberia	Peru	Macedonia
Benin	Ecuador	Libyan Arab Jamahiraya	Philippines	Timore-Leste
Bhutan	El Salvador	Lithuania	Poland	Togo
Bolivia	Equatorial Guinea	Madagascar	Portugal	Tunisia
Bosnia and	Eritrea	Malawi	Qatar	Turkey
Herzegovina	Estonia	Malaysia	Republic of Korea	Turkmenistan
Botswana	Ethiopia	Maldives	Republic of Moldova	Tuvalu
Brazil	Fiji	Mali	Romania	Uganda
Brunei Darussalam	Gabon	Marshall Islands	Russian Federation	Ukraine
Bulgaria	Gambia	Mauritania	Rwanda	United Republic of Tanzania
Burkina Faso	Georgia	Mauritus	Saint Vincent and the	Uruguay
Burundi	Ghana	Mexico	Grenadines	Uzbekistan
Cambodia	Guam	Micronesia (Federated	Sao Tome and Principles	Vanuatu
Cameroon	Guatemala	States of)	Senegal	Venezuala (The Bolivian Republic of)
Cape Verde	Guinea	Mongolia	Seychelles	Viet Nam
Central African	Guinea-Bissau	Morocco	Sierra Leone	Yemen
Republic	Guyana	Mozambique	Singapore	Zambia
Chad	Haiti	Myanmar	Solomon Islands	Zimbabwe
China	Honduras	Namibia	Somalia	
Columbia	India			
Comoros	Indonesia			
Congo	Iraq			
Cote d'Ivoire	Japan			

_____ _____

Applicant's Signature Date (mm/dd/yyyy)

PART 4: Tuberculosis Test – TO BE COMPLETED BY HEALTHCARE PROVIDER

If skin test is required, please administer or provide documentation of a skin test performed within 12 months prior to form's deadline.
Tuberculin Test (Skin test OR blood test)

Skin Test - Date Placed: _____ /_____ /_____ Date Read: _____ /_____ /_____ Result: _____mm
OR
Blood Test - Immunoassay blood test (IGRA) Date: _____ /_____ /_____ Result (circle): Negative Positive

****If TB test is positive or if there is a history of positive TB test and no chest x-ray:**

Date of Chest X-Ray (within last 12 months): _____ /_____ /_____ Result (circle): Normal Abnormal
OR
Documented INH therapy - Date treatment started: _____ /_____ /_____ Date treatment completed: _____ /_____ /_____

_____ _____
Healthcare Provider Name **Healthcare Provider Signature**

PART 5: Immunizations – TO BE COMPLETED FOR ALL STUDENTS BY A HEALTHCARE PROVIDER OR OFFICIAL OUTSIDE RECORDS MAY BE SUBMITTED

REQUIRED

Polio
Attached lab report showing positive immunity
-or-
1) Date: _____ /_____ /_____ 2) Date: _____ /_____ /_____ 3) Date: _____ /_____ /_____

Tetanus-Diptheria given within last 10 years -OR- **Tetanus/Diphtheria/Pertussis** given within last 10 years.
1) Date: _____ /_____ /_____ 2) Date: _____ /_____ /_____

Measles, Mumps, Rubella (MMR) 2 doses at least 1 month apart
1) Date: _____ /_____ /_____ 2) Date: _____ /_____ /_____

Meningoccocal (Meningitis) (or waiver)
Date: _____ /_____ /_____

Hepatitis B (HBV) (or waiver)
1) Date: _____ /_____ /_____ 2) Date: _____ /_____ /_____ 3) Date: _____ /_____ /_____
Given at least 4 weeks after dose 1 Given at least 16 weeks after dose 1, 8 weeks after dose 2

STRONGLY RECOMMENDED

Hepatitis A If Twinrix, please notate
1) Date: _____ /_____ /_____ 2) Date: _____ /_____ /_____

Varicella (chicken pox) or notate if listing date of disease
1) Date: _____ /_____ /_____

2) Date: _____ /_____ /_____ **Given at least 30 days after dose 1**

Human Papillomavirus (HPV)
1) Date: _____ /_____ /_____ 2) Date: _____ /_____ /_____ 3) Date: _____ /_____ /_____

_____ _____
Healthcare Provider Name **Healthcare Provider Signature**

_____ _____
Applicant's Signature Date (mm/dd/yyyy)

PART 6: Personal Information – TO BE COMPLETED BY ALL STUDENTS

Height _____ Weight _____

PAST/CURRENT PERSONAL MEDICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING:

HEART/LUNGS: ☐ Asthma ☐ Heart Disease ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol	**EARS/EYES/NOSE/THROAT** ☐ Chronic Sinus Infections ☐ Eye Disorders (other than glasses or contacts) ☐ Hearing Loss ☐ Nasal Allergies/Hayfever	**MENTAL HEALTH** ☐ ADHD/ADD ☐ Anorexia (Eating Disorder) ☐ Bulimia (Eating Disorder) ☐ Depression ☐ Other Mental Health Problems	**SKIN** ☐ Eczema ☐ Psoriasis ☐ Hives	**INFECTIOUS DISEASES** ☐ Chickenpox/Varicella ☐ Hepatitis Type: ☐ Infectious Mononucleosis ☐ Other
ENDOCRINE: ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder	**STOMACH/BOWEL** ☐ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Ulcerative Colitis/Chron's ☐ Other Liver, Stomach, or Bowel Disease	**HEMATOLOGY/ONCOLOGY** ☐ Anemia ☐ Bleeding Disorders	**STDs** ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD	**SOCIAL HISTORY** ☐ Do you smoke? ☐ Do you drink alcohol? ☐ Do you exercise regularly? ☐ Do you take recreational drugs?
KIDNEY: ☐ Chronic Kidney or Bladder Disease ☐ Kidney Stones	**NEUROLOGICAL** ☐ Concussions ☐ Convulsions/Seizures ☐ Migraines/Severe Headaches	**ORTHOPEDICS** ☐ Arthritis ☐ Fractures/Broken Bones	**SURGICAL HISTORY** ☐ Appendectomy ☐ Adenoidectomy ☐ Ear Tubes ☐ Knee ACL Repair ☐ Splenectomy ☐ Tonsillectomy ☐ Other Prior Surgeries	**OTHER HISTORY** ☐ Previous Hospitalizations
If other checked for any condition, please specify:				☐ **NO SIGNIFICANT HEALTH PROBLEMS**

ALLERGY TO: (Circle Yes or No. If yes, please list.) **Does student need to carry an EpiPen?** Yes No

Medication: Yes No

_____

Insect bites/Bee stings: Yes No

_____

Foods: Yes No

_____

Other (including environmental): Please explain

_____

_____ _____

Applicant's Signature Date (mm/dd/yyyy)

CURRENT MEDICATIONS: Please list any prescription and over the counter medications, including birth control pills.

Name	Dose	How Taken

[ ] None

WAIVER OF IMMUNIZATION – HEPATITITS B

I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at any time. I have received and reviewed the information regarding Hepatitis B and the availability and effectiveness of the Hepatitis B vaccine. I have chosen not to be vaccinated (or I am unable to provide current vaccination records) against Hepatitis B.

_____ _____

Student Signature **Date**

_____ _____

If student is a minor, signature of parent/guardian **Date**

WAIVER OF IMMUNIZATION – MENINGOCCOCAL (MENINGITIS)

I have received and reviewed the information regarding meningococcal disease and the availability and effectiveness of the meningococcal vaccine. If in the future I want to be vaccinated with meningococcal vaccine, I can receive the vaccination at any time. I have chosen not to be vaccinated against meningococcal disease.

_____ _____

Student Signature **Date**

_____ _____

If student is a minor, signature of parent/guardian **Date**

RELIGIOUS EXEMPTION

Religious exemption for immunizations is allowed if the responsible person objects in good faith and in writing that the immunizations violate his/her religious beliefs. *The Religious Exemption Form* can be obtained via our website at www.sc.edu.bs or by visiting the Admissions Office. Medical exemption is allowed if a physician provides a detailed letter indicating that immunizations are medically inadvisable. The exemption forms and letters are subject to Medical Form submission deadline

_____ _____

Applicant's Signature Date (mm/dd/yyyy)