

I am the parent or legal guardian of,
currently a minor, whose date of birth is/ / (mm/dd/yyyy). I authorize Health and
Wellness Services of Tompkins Cortland Community College to provide medical and/or mental
health care to my student, including nursing care, and mental health counseling. I understand
that should my student need more invasive, diagnostic, or surgical procedures, attempts will be
made to connect with me, time and conditions permitting. I further understand once my student
reaches their 18th birthday, my consent for treatment is no longer required.

Guardian Signature	Date	
		MM/DD/YYYY
Guardian Printed		
Student Name	D.O.B	
		MM/DD/YYYY
Home Address		
Country of Origin	Date of Entry	
	MM/DD/	YYYY



# Certificate of Health Statement International Physical Exam

**STUDENT**: Two Weeks before Start of Semester, upload this document to the Student Wellness Portal after having it completed by a physician with all supporting documentation. Link: https://tompkinscortland.studenthealthportal.com; you will need Student ID # and Email for New Registrants. Alternatively, mail to: TC3 Health Services, Tompkins Cortland Community College, 170 North St, PO Box 139, Dryden NY, 13053-0139. Or fax to: 607-844-6533, print clearly on the fax cover sheet: Student's Name, DOB, and "Nursing Student."

### TO BE COMPLETED BY PHYSICIAN:

Patient Name:	Date of Birth		
	MM/DD/YYYY		
Height Weight			
Blood Pressure / Pulse	Temperature		
Gross Vision ODOS			
Gross Hearing Right Ear	_ Left Ear		

Note to Physician: Clinical Evaluation - Check each item in appropriate column, "NE" is not evaluated

Attribute	Normal	Abnormal	NE	Notes: (describe abnormal)
Head, Ears, Eyes, Nose, Neck				
Heart				
Lungs				
Abdomen				
Genitourinary				
Musculoskeletal				
Neurological				

Please Upload to Student Wellness Portal: https://tompkinscortland.studenthealthportal.com

(continued on next page)



# **Certificate of Health Statement International Physical Exam**

#### TO BE COMPLETED BY PHYSICIAN:

In your assessment, is this patient mentally, physically and emotionally ready for the emotional and physical rigors for a college curriculum? If not, please explain your answer on separate paper and attach to form.

Will any accommodations be needed while attending college?

Physician Signature

Date\_\_\_\_\_ Physician Stamp:

MM/DD/YYYY



# Certificate of Health Statement International Vaccination Documentation

Vaccinations require additional proof of administration, attach necessary documents. All dates should be in MM/DD/YYYY format.

## Measles/Mumps/Rubella (MMR)

Option 1: MMR Vaccination	
Dose Date (1)	Dose Date (2)
Option 2: Titers	
Measles Titer Date	Result:
Mumps Titer Date	Result:
Rubella Titer Date	Result:

\_\_\_\_\_

Attach copies of laboratory results for titers.

## Meningitis

Vaccinations must have been received within five (5) years of submission.

Option 1: Menomune™	Option 2: I have had the	Option 3: I have had the
(MPSV4) Vaccine	Menactra™ (MCV4)	Meningococcal B
Dose Date	Vaccine	Vaccine (2-dose)
	Dose Date	Dose Date (1)
		Dose Date (2)

#### Option 4: Waiver

I will not obtain immunization against meningococcal meningitis disease. I have read, or have

had explained to me, the information regarding meningococcal meningitis disease.

I understand the risks of not receiving the vaccine.

Waiver	Signature
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Please Upload to Student Wellness Portal: https://tompkinscortland.studenthealthportal.com



# Certificate of Health Statement International Vaccination Documentation Tuberculosis TB Screening/Testing

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? **Yes / No** 

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease?

Yes / No

#### If yes, please CIRCLE the country on page 6

Have you had frequent or prolonged visits to one or more of the countries or territories listed above with a high prevalence of TB disease? Yes / No

#### If yes, CHECK the countries or territories on page 6

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? **Yes** / **No** 

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? Yes / No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?

Yes / No

If the answer is YES to any of the above questions, Tompkins Cortland Community College requires that you receive TB testing as soon as possible, at minimum prior to the start of the semester. This must be done by your healthcare provider, see page 5.



**Certificate of Health Statement International Vaccination Documentation Tuberculosis TB Screening/Testing** 

### Tuberculosis Test - All dates should be in MM/DD/YYYY format

**Option 1: Two (2) Negative PPD** 

Placement Date	Result Date		Result	_mm
Within 6 Months of Clinical Rotation	on:			
Placement Date	Result Date		Result	_mm
Option 2: Two (2) Negative PPD	1-3 weeks ap	art		
Placement Date	Result Date		Result	_mm
Placement Date	Result Date		Result	_mm
Option 3: QuantiFERON Gold T	B Test			
Date Result				
Option 4: Positive TB Result, Chest X Ray required within 6 months prior to clinical				
rotation unless medically contraindicated.				
X-Ray Date	Result			
Must provide evidence of negative chest X-Ray				
Treatment for Positive Skin Test? Yes / No				
If yes, describe medications and duration:				

#### **Country Reference - INCLUDE WITH PAPERWORK**

ChadGuyanaMongoliaSao Tome and PrincipeVietnam (Socialist Republic of)ChinaHaitiMontenegroSenegalYemen		1		Country Reference -	INCLUDE WITH PAPERWORK
AlgeriaComorsRepublic ofNambiaSingapreAngolaCongoraqNauruSolomon IslandsAnguilaOde d'ivoireKazakhstanNepalonaSouth SudanArgentinaDemocratic People's Republic of the CongaKinstaiNigaraSutansaAzerbaijanDibotiKwaitNigeriaSudanBagladeshDimointa Republic Of the CongaKwaitaNigeriaSudanBagladeshDimointa Republic CuaoroKyrystanNotter Mariana IslandSudanBagladeshEdavaroKavaitanNaterna IslandSudanBelarusElasladoriEdavaroPalavanTaikistanBilandEutoraLeosthonPalauTaikistanBolindFitteaLeosthonPanamaTaikistanBolindFitteaLibariaPalauTaikistanBolindFitteaLibariaPalauTaikistanBolindFitteaLibariaPalauTaikistanBolindFitteaMadagascoPalauTaikistanBolindSonoMadistanPalauTaikistanBolind SongaMainaPalauTaikistanBolind SongaMariaPalauTaikistanBolind SongaMariaPalauTaikistanBolind SongaNagaraPalauTaikistanBolind SongaNagaraPalauTaikistanBolind SongaNagaraPalauTaikistanBolind SongaNagara <t< td=""><td>Afghanistan</td><td>Colombia</td><td>Indonesia</td><td>Myanmar</td><td>Sierra Leone</td></t<>	Afghanistan	Colombia	Indonesia	Myanmar	Sierra Leone
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Central African RepublicGuinea-BissauMicronesia (Federated States of)Saint Vincent and the GrenadinesVenezuela (Bolivarian Republic of)ChadGuyanaMongoliaSao Tome and PrincipeVietnam (Socialist Republic of)ChinaHaitiMontenegroSenegalYemen	Cambodia	Guatemala	Mauritius	Russian Federation	Uzbekistan
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	Chad	Guyana	Mongolia	Sao Tome and Principe	Vietnam (Socialist Republic of)
	China	Haiti	Montenegro	Senegal	Yemen
SAR Honduras Morocco Serbia Zambia	China, Hong Kong SAR	Honduras	Morocco	Serbia	Zambia
China, Macao SAR India Mozambique Seychelles Zimbabwe	China, Macao SAR	India	Mozambique	Seychelles	Zimbabwe



# Certificate of Health Statement International Vaccination Documentation

### **OPTIONAL: COVID-19 Vaccination**

Vaccinations require additional proof of administration, attach necessary documents.

Dose 1:	
Date:	Manufacturer:
Dose 2:	
Date:	Manufacturer:
Dose 3:	
Date:	Manufacturer: