Authorization to Treat a Minor

Guardian Consent

International

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

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

Name____ Date of Birth___________________

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 OD___________ OS___________

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				

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Name____ Date of Birth_________________

(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

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Name____ Date of Birth___________________

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™ (MPSV4) Vaccine

Dose Date____________

Option 2: I have had the Menactra™ (MCV4) Vaccine

Dose Date_____________

Option 3: I have had the Meningococcal B Vaccine (2-dose)

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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Name____ Date of Birth__________________

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**.

Name____ Date of Birth___________________

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:

Placement Date ______________ Result Date ______________ Result_______________mm

Option 2: Two (2) Negative PPD 1-3 weeks apart

Placement Date ______________ Result Date ______________ Result_______________mm

Placement Date ______________ Result Date ______________ Result_______________mm

Option 3: QuantiFERON Gold TB 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:

____

____

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

Name____ Date of Birth________________

Country Reference - INCLUDE WITH PAPERWORK

Afghanistan	Colombia	Indonesia	Myanmar	Sierra Leone
Algeria	Comoros	Iran (Islamic Republic of)	Namibia	Singapore
Angola	Congo	Iraq	Nauru	Solomon Islands
Anguilla	Côte d'Ivoire	Kazakhstan	Nepal	Somalia South Africa
Argentina	Democratic People's Republic of Korea	Kenya	Nicaragua	South Sudan
Armenia	Democratic Republic of the Congo	Kiribati	Niger	Sri Lanka
Azerbaijan	Djibouti	Kuwait	Nigeria	Sudan
Bangladesh	Dominican Republic Ecuador	Kyrgyzstan	Northern Mariana Islands	Suriname
Belarus	El Salvador	Lao People's Democratic Republic	Pakistan	Swaziland
Belize	Equatorial Guinea	Latvia	Palau	Tajikistan
Benin	Eritrea	Lesotho	Panama	Thailand
Bhutan	Estonia	Liberia	Papua New Guinea	Timor-Leste
Bolivia (Plurinational State of)	Ethiopia	Libya	Paraguay	Togo
Bosnia and Herzegovina	Fiji	Lithuania	Peru	Trinidad and Tobago
Botswana	French Polynesia	Madagascar	Philippines	Tunisia
Brazil	Gabon	Malawi	Poland	Turkmenistan
Brunei Darussalam	Gambia	Malaysia	Portugal	Tuvalu
Bulgaria	Georgia	Maldives	Qatar	Uganda
Burkina Faso	Ghana	Mali	Republic of Korea	Ukraine
Burundi	Greenland	Marshall Islands	Republic of Moldova	United Republic of Tanzania
Cabo Verde	Guam	Mauritania	Romania	Uruguay
Cambodia	Guatemala	Mauritius	Russian Federation	Uzbekistan
Cameroon	Guinea	Mexico	Rwanda	Vanuatu
Central African Republic	Guinea-Bissau	Micronesia (Federated States of)	Saint Vincent and the Grenadines	Venezuela (Bolivarian Republic of)
Chad	Guyana	Mongolia	Sao Tome and Principe	Vietnam (Socialist Republic of)
China	Haiti	Montenegro	Senegal	Yemen
China, Hong Kong SAR	Honduras	Morocco	Serbia	Zambia
China, Macao SAR	India	Mozambique	Seychelles	Zimbabwe

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Name____ Date of Birth___________________

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: ______________________________