TOMPKINS CORTLAND COMMUNITY COLLEGE

Certificate of Health Statement

Release Authorization

I hereby authorize Tompkins Cortland Community College to furnish to the institutions named below medical records and information pertaining to medical history, mental or physical condition, or treatment of the person named below for the purposes of ensuring that students/faculty for any other purpose reasonably related to these activities.

I understand that the institutions named below may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Please release information to: all agencies used for clinical experiences as necessary.

I further understand that I have a right to receive a copy of this authorization upon my request.

Signed_____ Date_____

Witness_____ Date_____

Patient Name_____ D.O.B_____

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

Name_____ Date of Birth_____

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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 _____

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, Face, Neck, Scalp				
Nose				
Mouth, Tongue, Throat				
Ears, General				
Eyes				

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Name_____ Date of Birth_____

Lungs and Chest				
Heart (thrust, size, sounds, rhythm)				
Vascular (varicosities)				
Abdomen and Viscera (hernia)				
Endocrine - Thyroid				
Genitourinary				
Upper Extremities				
Lower Extremities				
Spine, Musculoskeletal				
Skin, Lymphatic				
Neurological				

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

_____

_____

_____

Physician Signature_____

Date_____ Physician Stamp:

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Vaccination Documentation

Vaccinations require additional proof of receipt, attach necessary documents.

Tuberculosis Testing

Option 1: Two (2) Negative PPD within 6 months of Clinical Rotation, 1-3 weeks apart

Placement Date _____ Result Date _____ Result_____mm

Placement Date _____ Result Date _____ Result_____mm

Option 2: QuantiFERON Gold TB Test

Within 90 Days of Clinical Rotation:

Date _____ Result_____

If Positive TB, 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:

_____

_____

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Name_____ Date of Birth_____

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Certificate of Health Statement

Vaccination Documentation

Continued

Vaccinations require additional proof of receipt, attach necessary documents.

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_____

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

Name_____ Date of Birth_____

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Vaccination Documentation

Continued

Varicella (Chickenpox, Shingles)

Option 1: Vaccination

Dose Date (1) _____ Dose Date (2) _____

Option 2: Titer

Titer Date: _____ Result: _____

Attach copies of laboratory results for titers.

Tetanus

Recommended within 10 years

Dose Date_____

TDAP

Recommended within 5 years

Dose Date_____

Hepatitis B

Option 1: Vaccination

Dose Date (1) _____ Dose Date (2) _____ Dose Date (3)_____

Option 2: Titer

Titer Date: _____ Result: _____

Attach copies of laboratory results for titers.

Annual Influenza

Required for all students. Fall Admits can wait until the newest version for the upcoming season if they do not have a current one. Spring Admits are required to have a current version to start clinical.

Date: _____

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

Name_____ Date of Birth_____

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Vaccination Documentation

Continued

OPTIONAL: COVID-19 Vaccination

May be required by clinical sites, please provide information if available

Dose 1:

Date: _____ Manufacturer: _____

Dose 2:

Date: _____ Manufacturer: _____

Dose 3:

Date: _____ Manufacturer: _____