Cape May County Technical School District
188 Crest Haven Road
Cape May Court House, NJ 08210
(609) 380-0200 Fax 609-465-4962

Adult/Post Secondary Student Information
Please Print

Name: _____
Last First MI Maiden Name

Address: _____
Street City State Zip

Telephone: _____ Date of Birth ___/___/___ Name of Program Enrolled In: _____

Health Insurance
Subscriber Name: _____ Name of Plan: _____ Plan Id#: _____

Person To Notify In Case of Emergency

Name: _____ Relationship: _____

Address: _____ Telephone(s): _____

Family Physician and Health Information

Physician's Name: _____ Telephone: _____

Indicate here any information we can share with the emergency medical personnel (E.M.T., Hospital) in the event of an emergency:

Health Conditions: _____

Medications you are currently taking: _____

_____

ALLERGIES: Medications (list)_____ Food (list):_____

Latex Allergy: **YES** NO Insects Allergy (Indicate which ones): _____

Do you require emergency medication if exposed to the above allergen (circle)? NO YES
If Yes, medication name/dose/route (ie. Epinephrine auto injector 0.3 mg injection):

_____

Student Signature: _____ Date: ____/____/____

Cape May County Technical School District - Adult/Post-Secondary Applicant Health History

Medical History: (To be completed by student)

Name: _____ Name of Program Enrolled In: _____
Last First MI

Medical History

	YES	NO	If YES, describe or indicate condition:
Headaches, fainting spells or dizziness?	___	___	_____
Vision difficulties or eye trouble, color deficient	___	___	_____
Frequent respiratory symptoms?(colds, pneumonia, etc.)	___	___	_____
Asthma, reactive airway or other lung conditions?	___	___	_____
Do you have or ever been treated for tuberculosis	___	___	_____
Ear or hearing difficulties?	___	___	_____
Blood diseases, anemia?	___	___	_____
Diabetes?	___	___	_____
Hypertension or hypotension? (high or low blood pressure)	___	___	_____
Heart disease?	___	___	_____
Circulation problems? (Varicose veins, etc.)	___	___	_____
Hernia?	___	___	_____
Orthopedic conditions or back pain?	___	___	_____
Arthritis?	___	___	_____
Painful or swollen joints, muscles, bursitis, neuritis, etc.	___	___	_____
Muscular weakness or condition?	___	___	_____
Gastrointestinal disorder or condition?	___	___	_____
Jaundice or hepatitis?	___	___	_____
Genitourinary problems? (kidney stones, bladder problems)	___	___	_____
Neurological conditions? (seizures, etc.)	___	___	_____
Mental/Nervous conditions?	___	___	_____
Operations?	___	___	_____
Any other conditions?	___	___	_____
Do you use:			
Hearing aides	___	___	which ear(s) _____
Glasses	___	___	_____
Contact lenses	___	___	hard or soft? _____
Other adaptive devices	___	___	_____
Physical limitations the school should be aware of	___	___	_____
Are you under the care of a physician?	___	___	_____
Do you take any medications?	___	___	Name of medication(s): _____

_____

I attest that the above information is true and accurate:

Student signature: _____ Date: _____

Information to be completed by Licensed Physician, Physician Assistant or Advanced Nurse Practitioner.

Student Name: _____ D.O.B. _____/_____/_____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

	Normal	Abnormal	Comments
General Appearance	_____	_____	_____
Eyes Vision R 20/___ L 20/____	_____	_____	_____
Ears	_____	_____	_____
Throat/Mouth/Dental	_____	_____	_____
Nose/Sinuses	_____	_____	_____
Lungs/Chest	_____	_____	_____
Heart	_____	_____	_____
Vascular System	_____	_____	_____
Abdomen	_____	_____	_____
Upper Extremities	_____	_____	_____
Lower Extremities	_____	_____	_____
Spine	_____	_____	_____
Skin	_____	_____	_____
Neurological	_____	_____	_____
Psychiatric/Mental Illness	_____	_____	_____
Menses	_____	_____	_____

Current Medications: _____

Health History and Present Health Conditions: _____

Operations/Accidents/Injuries: _____

Tetanus/Diphtheria Toxoid (Required within last 10 years): ____/____/____ Type (circle one): Td or Tdap

*Health Care and Childcare Students: At least one **tdap** must be given in adulthood followed with 10 year td booster.*

Is applicant's health condition sufficient to endure the physical demands of the program specified on page two (2)?

____ Yes ____ No: Explain any limitations the applicant has: _____

_____

Is applicant mentally and emotionally in condition to participate in the program designated on page two (2)?

____ Yes ____ No: Explain: _____

Is applicant free from any evidence of infectious, contagious or communicable disease which could reasonably be expected to be transmitted during the course of rendering services in the specified program?

____ Yes ____ No: Explain: _____

PHYSICIAN'S NAME PRINTED: _____

SIGNATURE:_____ **Date**_____

Medical Office Stamp Required

Cape May County Technical School
Adult/Post-Secondary Physical Examination – Health Care and Childcare Students

Student Name_____ Date of Birth_____/_____/_____

CHILDCARE STUDENTS *MUST PROVE MMR and VARICELLA IMMUNIZATIONS or have lab titers drawn.*

Lab Titers	**Health Care Students Attach copy of lab reports***	Vaccine given (date) ** (If titers do not show immunity or have "equivocal" result)	Type/Manufacturer of Vaccine Rec'd **
Measles (Rubeola) IGg	☐ Immune ☐ Equivocal/not immune	_____ / _____ / _____	Type: _____
Mumps IGg	☐ Immune ☐ Equivocal/not immune	_____ / _____ / _____	Type:_____
Rubella IGg	☐ Immune ☐ Equivocal/not immune	_____ / _____ / _____	Type:_____
Varicella IGg	☐ Immune ☐ Equivocal/not immune	_____ / _____ / _____	Type:_____

*Hepatitis B Vaccination Dates: #1 ___/___/___ #2 ___/___/___ #3___/___/___

*Hepatitis B - Post vaccination titer (if done): ___/___/___ Result:_____

2-step PPd is required of all Healthcare workers if this is your 1st TB/Mantoux test, or, if it has been more than a year since your last annual test.
Childcare students only need to submit one current TB/Mantoux test.

TB Skin Testing
Date given: _____
Date Read: _____
Reading: _____mm Result is: Negative Positive

Booster (1-2 weeks after 1st test)
Date given:_____
Date Read: _____
Reading: _____mm Result is: Negative Positive

CHEST X-RAY IF POSITIVE or PAST POSITIVE MANTOUX: DATE:_____ RESULT: _____

Certification of Health Care Provider (This information is required)

Name: _____

Signature: _____

Date: _____/_____/_____

Medical Office Stamp Required

** If student is applying for a Hepatitis B vaccination or Hepatitis B waiver the attached waiver form must be completed.*
***Medical contraindications to vaccination, with the specific reason and type of vaccine that is medically contraindicated, must be written by physician, Certified PA or Certified Advance Practice nurse.*

Review: SN Nurse Initials: ____ Date: ____ Approved for Clinical? YES NO

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Waiver for Hepatitis B vaccination and post-vaccination titers -

Hepatitis B Vaccination: OSHA Bloodborne Pathogens Standard 1910:1030, Title 29 of the Federal Register stipulates that Hepatitis B Vaccine must be made available to all persons occupationally exposed to blood or other potentially infectious materials. My physician and I have discussed the importance of vaccination against Hepatitis B but I am declining vaccinations.

Student Name
PRINT: _____ Signature: _____ Date:____/____/____