ATTENTION STUDENT TEACHERS

All 4 pages must be completed and submitted to the Student Health Service by the date indicated on your Student Teaching Clearance email.

(Pages 1 and 2 by you, pages 3 and 4 by your physician)

If you have not received an email from the Student Health Service regarding Student Teaching health clearance requirements, please call our office and ask us to forward you the information as soon as possible.

The completed forms should be mailed, faxed or emailed to the office indicated above. Once the packet is received and reviewed by the Assistant Director, the Student Teaching office will be notified and you will be cleared for student teaching. If there is any information missing from this packet or there is additional information needed, the student will be contacted and alerted.

Any additional questions or concerns, please call our office and speak with our staff.
TO BE COMPLETED BY STUDENTS:

DEMOGRAPHICS:

Student Name: __________________________________________

Address: ____________________________________________

Street City State Zip Code Country

Cell Phone: ____________________________ Other Phone: ____________________________

Parent or Guardian: __________________________________________

Address: ____________________________________________

Cell Phone: ____________________________ Work Phone: ____________________________

Parent or Guardian Relationship: ____________________________

Primary Health Provider: __________________________________________

Address: ____________________________________________

Phone: ____________________________ Fax: ____________________________

Emergency Contact if Other Than Parent or Guardian:

Person: ____________________________________________

Address: ____________________________________________

Cell Phone: ____________________________ Work Phone: ____________________________

Emergency Contact Relationship: ____________________________

Insurance Information:

PLEASE INCLUDE A PHOTOCOPY OF FRONT AND BACK OF STUDENT’S HEALTH INSURANCE CARD.

Primary Insurance Company Name: ____________________________________________

Member ID: ____________________________ Policy Holder’s Name: ____________________________

Student Relationship to Insured: ☐ Dependent ☐ Self ☐ Spouse

HEALTH HISTORY:

Are you on the Varsity Athletics Roster? ☐ Yes ☐ No

Diseases in parents and grandparents: eg. Diabetes, Hypertension, Arthritis, Cancer, Heart Disease, Depression, etc:

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Diseases in student: check box if history of this condition exists in student:

Infectious Disease

☐ Chicken Pox

☐ Frequent Respiratory Infections

☐ Mononucleosis

☐ Positive TB Skin Test

☐ Tuberculosis

☐ Malaria

☐ HIV/AIDS

☐ Hepatitis A, B, or C

☐ Pneumonia

☐ Sexually Transmitted Infection

Chronic Medical Disorders

☐ Diabetes

☐ Seizure Disorder

☐ Anemia

☐ Sickle Cell Disease

☐ Heart Abnormality

☐ Kidney Disease

☐ Chronic Intestinal/Stomach Problem

☐ Arthritis

☐ Respiratory Allergies

☐ Hives

☐ Asthma

☐ Cancer

☐ Orthopedic Problems

Neurologic/Psychiatric Problems

☐ Head Injury/Concussion

☐ Emotional Disorder

☐ Depression

☐ Anxiety

☐ Attention Deficit Disorder

☐ Eating Disorder

☐ Hearing Deficit

☐ Visual Deficit

☐ Speech Deficits

☐ Fainting

☐ Alcohol/Drug Addiction

☐ Migraine Headaches

☐ Learning Disabilities

Please list any MEDICAL PROBLEMS not noted above. Please clarify any positive responses.

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Severe Injuries: ☐ Yes ☐ No Explain: ____________________________

Operations: ☐ Yes ☐ No Explain: ____________________________

CURRENT MEDICATIONS:

ALLERGIES: (Please Specify) ☐ No Allergies

Allergies to Medication:

Allergies to Food:

Allergies to Insects:

Student Signature: __________________________________________
Student Name: __________________________________________________________________________________________________________   Date of Birth: _________________________________________________________

TO BE COMPLETED BY STUDENT’S PRIMARY HEALTH PROVIDER:

Provider Name: ______________________________________________________________________________________

Address: __________________________________________________________________________________________________

Phone: __________________ Fax: __________________

Please list any significant past or current medical, surgical, or psychiatric conditions: □ None

________________________________________________________________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________________________________________________________________

Please list any ongoing therapy, medications with dosages and directions: □ None

________________________________________________________________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________________________________________________________________

ALLERGIES: (Please Specify) □ No Allergies   Epipen Prescribed? □ Yes □ No

Allergies to Medication:

Allergies to Food:

Allergies to Insects:

Date of Exam: __________ Height: ______ Weight: ______ BMI: ______ BP: ______ P: ______

Please list all abnormal findings of your history and physical exam:  _______________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________________________________________________________________

Please use check off format below to document history and physical:

N = Normal  ABN = Abnormal  NE = Not Examined

<table>
<thead>
<tr>
<th>Systems</th>
<th>SEX: □ Male  □ Female</th>
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<tbody>
<tr>
<td></td>
<td>N  ABN  NE</td>
</tr>
<tr>
<td>Skin</td>
<td>Abdominal OrgansPLL</td>
</tr>
<tr>
<td>HEENT</td>
<td>Ano Rectal Area (If indicated)</td>
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<tr>
<td>Lungs</td>
<td>Orthopedic: Limbs</td>
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<tr>
<td>Heart</td>
<td>Spine</td>
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<tr>
<td>Blood Vessels</td>
<td>Endocrine</td>
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<tr>
<td>Lymphatics</td>
<td>Neurologic</td>
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</tbody>
</table>

Urinalysis:

<table>
<thead>
<tr>
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<th>N  ABN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose</td>
<td></td>
</tr>
<tr>
<td>Protein</td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td></td>
</tr>
</tbody>
</table>

Information required for Varsity Athletes:

Sickle Cell Trait: □ Present □ Absent □ Unknown

Do you recommend further evaluation? □ Yes □ No

Will you remain involved in this student's care? □ Yes □ No

Is this student able to participate in all physical activities including intercollegiate athletics? □ Yes □ No

Is this student able to meet the physical and emotional demands of college? □ Yes □ No

Provider Signature: ________________________________
STUDENT TEACHING CLEARANCE TST

To be filled out by student’s primary health provider or provide copies of physician documented immunization records.

Banner ID# N __________ Office Stamp: ________________

Student Name: _________________________________________

Date of Birth: ________________

A Tuberculosis Skin Test (TST) completed on or after the date indicated on your Student Teaching Health Clearance email is **mandatory** for all Student Teachers. If you have already completed a TST on or after the appropriate date, have your doctor fax us the results. If you did not receive your Student Teaching Clearance email, please call our office and ask us to forward you the information as soon as possible.

**PPD** (on or after the date indicated on your Student Teaching Clearance email)

☐ PPD test given: Date Given: __________ Date Read: __________ Result: __________

M/D/Y M/D/Y

(Record actual mm of induration, transverse diameter, if no induration, write “0”)

☐ Chest x-ray (required if tuberculin skin test is positive) Result: ☐ Normal ☐ Abnormal

PLEASE SUBMIT COPY OF WRITTEN CHEST X-RAY REPORT TO STUDENT HEALTH SERVICE.

Provider Name: ___________________________ Signature: ___________________________