COLBY COMMUNITY COLLEGE
PERSONAL HEALTH HISTORY

NAME_____CCC STUDENT ID NO._____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP CODE

DATE OF BIRTH_____GENDER_____MARITAL STATUS_____STUDENT PHONE_____

PERSON TO NOTIFY IN AN EMERGENCY_____RELATIONSHIP_____
(Parent, Guardian, or Spouse)

ADDRESS OF ABOVE_____HOME PHONE_____CELL PHONE_____

HEALTH INSURANCE_____
NAME OF COMPANY POLICY NUMBER TELEPHONE NUMBER

FAMILY HEALTH HISTORY

CHECK EACH ITEM	YES	NO	RELATION	CHECK EACH ITEM	YES	NO	RELATION	CHECK EACH ITEM	YES	NO	RELATION
TUBERCULOSIS				HEART TROUBLE				EPILEPSY OR CONVULSIONS			
DIABETES				CANCER				NERVOUS/MENTAL DISORDER			
HIGH BLOOD PRESSURE				ASTHMA, HAY FEVER, HIVES				BLEEDING/CLOTTING DISORDER			

PERSONAL HISTORY

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING:
(IN LINES OF MULTIPLE STSTEMENTS CROSS OUT THE INAPPLICABLE WORDS) EXPLAIN ALL ANSWERS BELOW.

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
CHICKEN POX			SEIZURES/CONVULSIONS		
RHEUMATIC FEVER			HIGH BLOOD PRESSURE		
HEART PROBLEMS			HIV		
SKIN PROBLEMS			TUBERCULOSIS		
ALLERGIES/HAY FEVER			MIGRAINE HEADACHE		
ARTHRITIS			TOBACCO USE		
THYROID PROBLEMS			EMOTIONAL/MENTAL PROBLEMS		
STOMACH OR BOWEL PROBLEMS			MUMPS		
BLOOD DISORDER			MEASLES		
DIABETES			SURGERY		
ASTHMA			ALCHOL/DRUG ABUSE		
HEPATITIS/JAUNDICE			KIDNEY/BLADDER		
ORTHOPEDIC PROBLEMS					

CHECK EACH ITEM	YES	NO	IF YES, LIST
DO YOU TAKE MEDICATION?	O	O	_____
ARE YOU ALLERGIC TO ANY MEDICATIONS?	O	O	_____
DO YOU HAVE ANY ALLERGIES?	O	O	_____

STATEMENT OF AUTHORIZATION

I hereby certify that the above history is complete to the best of my Knowledge. Permission is hereby given to administer recommended Immunizations and to perform any necessary treatment and diagnostic studies.

If yes, or any other diseases/Problems, give details

_____

_____

_____

_____

_____
Signature of student Date

_____
Signature of Parent or Guardian (If under 18 years of age) Date

IMMUNIZATION RECORDS, MENINGOCOCCAL FORM, TB QUESTIONNAIRE REQUIRED TO BE ATTACHED TO THIS FORM

COLBY COMMUNITY COLLEGE
WAIVER FOR THE MENINGOCOCCAL VACCINATION

I have received and reviewed the information provided on the risk of meningococcal disease and the risks and benefits of the meningococcal vaccine. After reviewing the materials on the dangers of meningococcal disease, I choose to waive receipt of the meningococcal vaccine.

Printed Name:_____
Birthdate:____/____/____Student ID or Social Security Number_____

Student Signature_____Date_____

_____ _____
Parent/Legal Guardian Signature (If student is under 18 years of age) Date

OR

VERIFICATION OF VACCINATION

Printed Name:_____
Birthdate:____/____/_____Student ID or Social Security Number: _____

Student Signature_____Date_____

_____ _____
Parent/Legal Guardian Signature (If student is under 18 years of age) Date

I have received the meningococcal vaccine on_____(date).

_____ _____
Name of Provider (or attached copy of meningococcal vaccine verification) Provider Phone Number

_____ _____
Address of Provider City State Zip Code

_____ _____
Signature of Provider (or attached copy of meningococcal vaccine verification) Date

Please send or fax waiver and/or verification form to:

Colby Community College
Attention: Student Health
1255 S Range
Colby, KS 67701
Fax: (785) 460-4691

COLBY
COMMUNITY COLLEGE

Colby Community College TB Questionnaire

Last Name: **First Name:** **Student ID Number:** **Phone Number:**

_____ _____ _____ _____

About this Form:

- Tuberculosis, also known as TB, is a bacterial infection that attacks the lungs and sometimes other parts of the body. It is spread when someone infected with the disease coughs or sneezes and the bacteria is inhaled by someone nearby.
- Colby Community College requires **ALL** students to complete a tuberculosis screening questionnaire, per Kansas Statute #65-129e.
- Please submit this form before August 15 for the fall semester or December 15 for the winter/spring semester to avoid being dropped from pre-registered classes.
- Return to: Student Health

Please complete the following questions by circling Yes or No*:

1. Have you ever had a positive TB test?	**Yes**	**No**
2. Have you ever had the BCG vaccine which is given to prevent TB? **If yes provide document**	**Yes**	**No**
3. Have you ever had close contact with someone who was sick with TB?	**Yes**	**No**
4. Where you born in a country other than those listed below?	**Yes**	**No**
5. Have you ever traveled to and/or resided in a country for more than three months which is not listed below? If yes please write the country or countries in the blank: _____	**Yes**	**No**

***If the answer is yes to any of the questions above, Colby Community College requires evaluation by a health care provider.**

List of Exempt/Low Incidence/TB Countries**

(defined by the Department of Health and Environment)

Albania	Czech Republic	Luxembourg	Turks & Caicos Islands
American Samoa	Denmark	Malta	Great Britain & North Ireland
Andorra	Dominica	Nauru	United States Virgin Islands
Antigua & Barbuda	Fuji	Netherlands	United States of America
Australia	Finland	New Zealand	Wallis & Futuna Islands
Austria	France	Norway	
Bahamas	Germany	Saint Kitts & Nevis	
Barbados	Greece	Saint Lucia	
Belgium	Grenada	Samoa	
British Virgin Islands	Hungary	Slovakia	
Canada	Iceland	Slovenia	
Chile	Ireland	Spain	
Costa Rica	Italy	Sweden	
Cyprus	Jamaica	Switzerland	

****Students from countries other than those listed above are required to have a TB test. You must show proof of Quantiferon R blood result or current chest x-ray.**

I understand further testing may be required before attending class at Colby Community College. If testing is required I will be responsible for the cost. The information provided in this form is correct to the best of my knowledge.

Student Signature:_____Date:_____

If you are not sure on how to answer the questions above please contact the Student Health office at 785-460-5502. If you answer YES to any question you MUST go to Student Health.