

# John A. Gupton Student Health Form

Student Name \_\_\_\_\_

Last

First

MI

Address \_\_\_\_\_

Street

City

State

Zip

Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_

Male \_\_\_

Female \_\_\_

SSN \_\_\_\_\_

Citizen USA \_\_\_\_\_

Other \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Hair Color \_\_\_\_\_

Eye Color \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

## Health Care Provider Information (REQUIRED)

All students must complete BOTH sections

▶ TB Skin Test, IGRA Blood Test or Chest X-Ray

(MUST be within last year)

Date given \_\_\_\_\_

Results \_\_\_\_\_

Health care providers signature or stamp

▶ 1st dose Rubeola, Rubella, Mumps vaccination

Date MMR given \_\_\_\_\_

▶ 2nd dose Rubeola, Rubella, Mumps vaccination

Date MMR given \_\_\_\_\_

OR

▶ TITERS

Date \_\_\_\_\_

Results \_\_\_\_\_

Health care providers signature or stamp

**Hepatitis B (HBV) Immunization:** Hepatitis B (HBV) is a serious viral infection of the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. The disease is transmitted by blood and or body fluids and many people will have no symptoms when they develop the disease. The primary risk factors for Hepatitis B are sexual activity and injecting drug use. This disease is completely preventable. Hepatitis B vaccine is available to all age groups to prevent Hepatitis B viral infection. A series of three (3) doses of vaccine are required for optimal protection. Missed doses may still be sought to complete the series if only one or two have been acquired. The HBV vaccine has a record of safety and is believed to confer lifelong immunity in most cases.

**Check only one:**

\_\_\_ I hereby certify that I have read this information and I have had the entire series of the Hepatitis B vaccine.

\_\_\_ I hereby certify that I have read this information and I have elected not to receive the Hepatitis B vaccine.

\_\_\_ I hereby certify that I have read this information and I have elected to receive the Hepatitis B vaccine and/or I am in the process of receiving the complete three dose series of the Hepatitis B vaccine.

Signature of Student \_\_\_\_\_

Date \_\_\_\_\_

(Parent/Guardian must sign if student is under the age of 18)

## Immunization (advised but not required)

Tetanus (OR) TD \_\_\_\_\_ (Must be within the last 10 years)

## Physical Findings - check any problems which require on-going care

\_\_\_ Allergy

\_\_\_ Dermatology

\_\_\_ Hearing/Sight

\_\_\_ Anorexia/Bulimia

\_\_\_ Anemia

\_\_\_ Seizure disorder

\_\_\_ Obesity

\_\_\_ Genitourinary

\_\_\_ Cardiac/Heart

\_\_\_ Gastrointestinal

\_\_\_ Orthopedic

\_\_\_ Headaches/Migraine

\_\_\_ Pulmonary

\_\_\_ Blood Pressure Hyper/Hypo

\_\_\_ Immune disorders

Other: \_\_\_\_\_

\_\_\_ Diabetes

\_\_\_ Mental Illness/Anxiety/Depression

\_\_\_ Cholesterol

Other: \_\_\_\_\_

## Required medication, physical limitations, or ADA Request for Assistance

\_\_\_\_\_  
\_\_\_\_\_