

**DALTON STATE COLLEGE RESPIRATORY THERAPY PROGRAM
CERTIFICATE OF IMMUNIZATION**

See the back of this form for immunization requirements and acceptable documentation.

STUDENT INFORMATION

Dalton State College ID # _____ Age at time of application _____ Date of Birth ____/____/____

Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Term of Enrollment: (Please Circle) Fall Spring Summer 200____

In case of Emergency, please notify: _____ Relationship _____ Phone number (____) - ____ - ____

IMMUNIZATION INFORMATION (Specific immunization requirements are listed on reverse)

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR*	/ /	/ /			
MEASLES*	/ /	/ /			/ /
MUMPS*	/ /	/ /			/ /
RUBELLA*	/ /	/ /			/ /
Varicella (Chicken Pox)	/ /	/ /			(History of Varicella) / /
Tetanus-Diphtheria. (DTP, DtaP or TD)	/ /				
PPD (TB Skin Test or Chest x-ray if PPD positive)	/ /				/ / <input type="checkbox"/> PPD <input type="checkbox"/> Chest X-ray Result:
Hepatitis B**	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2-dose series <input type="checkbox"/> 3-dose series	/ /

* Not required if born before 1957.

** Hepatitis B is not required, but strongly recommended prior to clinical assignment. A waiver must be signed upon program admission if vaccine is refused.

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required.)

Name _____ Signature _____

Address _____ Date issued _____

Exemptions

Check the appropriate box, sign, and date if you are claiming exemption of the immunization requirement for one of the following reasons:

- Exemption on the grounds of permanent medical contraindication.
- Exemption on the grounds of temporary medical contraindication.
 - A. Pregnancy, expected delivery date: ____/____
 - B. Other, anticipated date of contraindication's end: ____/____

I understand that exemption for any of the reasons listed above subjects me to exclusion from campus/clinical site in the event of an outbreak of a disease for which immunization is required.

Student Signature _____

Date _____

Return this form to: Dalton State College, Respiratory Therapy Program
650 College Drive, Dalton, GA 30720
Keep a copy of this form for your records.

Dalton State College
Associate of Applied Science Degree in Respiratory Therapy Technology

STUDENT HEALTH SELF-ASSESSMENT
2008 – 2009

**THIS SIDE OF FORM IS TO BE FILLED OUT BY STUDENT BEFORE
GOING TO THE PHYSICIAN/NURSE PRACTITIONER FOR THE PHYSICAL EXAMINATION.**

Name of Student: _____ Year of Application: _____

Address: _____
Street and Number or P.O. Box City State ZIP

Age: _____ Phone: _____ Student ID# _____

IN AN EMERGENCY, PLEASE NOTIFY THE FOLLOWING INDIVIDUAL:

Name	Address	Relationship to Student
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1. Have you had any of the following? If yes, check the space in front of the condition.

<input type="checkbox"/> *Asthma/Respiratory Illness	<input type="checkbox"/> Hearing Problem	<input type="checkbox"/> Head Injury
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Eye Problem	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> *Heart Trouble	<input type="checkbox"/> Rupture
<input type="checkbox"/> Nephritis	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> *Tuberculosis
<input type="checkbox"/> Ill Effects from Medicine	<input type="checkbox"/> *Back Problem	<input type="checkbox"/> Manual Dexterity Problem
<input type="checkbox"/> Allergies: Please list: _____		

*Please provide prescribed treatment and dates: _____

2. At present, are you taking any prescribed drugs or medical treatment? _____ (Drug Screening required.)

If yes, what? _____

3. Have you had any emotional problems? _____ If yes, what? _____

4. Do you know any reason why you should not participate in normal physical exercise? _____
If yes, explain: _____

5. Please list any additional illnesses, operations, or injuries, and give dates: _____

6. Hepatitis B vaccine is recommended but not required. Students who elect not to take the vaccine will be required to sign a waiver.

Student Signature _____

Date _____

Dalton State College
Associate of Applied Science Degree in Respiratory Therapy Technology
PHYSICIAN'S REPORT FORM
2008 – 2009

**THIS REPORT OF PHYSICAL EXAMINATION MUST BE COMPLETED BY A
LICENSED PHYSICIAN/NURSE PRACTITIONER AND RETURNED TO DALTON STATE COLLEGE,
AS DIRECTED BY THE TECHNICAL DIVISION FACULTY.**

DATE OF EXAMINATION: _____ DATE OF STUDENT BIRTH: _____

NAME OF STUDENT: _____

Height _____ inches Weight _____ lbs. Pulse _____ Blood Pressure _____

Vision without glasses: R/20/ _____ L20/ _____ Vision with glasses: R/20 _____ L20/ _____

General condition of the following:

Teeth _____ Skeletal System _____

Lungs _____ Varicosities/Hemorrhoids _____

Heart _____ Respiratory Health _____

Abdomen _____ Allergies _____

Hernia _____ Mental Status _____

Genito-Urinary System _____ Prescribed Drugs _____

I have performed a complete health examination on this student and have determined that the student is free from any infectious or contagious disease and is physically, mentally, and psychologically capable of performing patient care activities.

Yes _____ No _____

IF NO, EXPLAIN: _____

Physician/Nurse Practitioner's Signature

Date

Title of Professional Completing this Form