HEALTH HISTORY
MADISON AREA TECHNICAL COLLEGE

TO THE STUDENT:

This examination and form is to be completed no sooner than three months prior to the date you begin classes. The information is needed for all Health Services Students. All programs have agreements with affiliating clinical agencies which require verification of compliance with the employee health standards.

This form must be completed before you will be allowed to go to clinical affiliation. In many programs, clinical experiences begin within the first two weeks of school. The form (BOTH SIDES) must be filled out completely.

Name ____________________

Social Security Number ____________________

Phone (Day)__________ (Eve)__________

Address ____________________

____

Program Title ____________________

Date of Birth ____________________ Sex ______

COMMUNICABLE DISEASES

Have you ever been treated for or have you tested positive for any of the following:

	Yes	No
Tuberculosis		
Hepatitis A		
Hepatitis B		

Have you ever had chicken pox?

Yes _____ No _____

Do you want to divulge information on any allergies, illnesses or disabilities that would require reasonable accommodations: Examples of these are: skin allergies, (latex glove allergies), lifting restrictions, hearing impairment, diabetes, drug allergies or other. Please describe.

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CAMPUS LOCATION

Madison __________ Watertown __________

Reedsburg __________ Fort Atkinson __________

DO YOU HAVE HEALTH INSURANCE?

Yes _____ No _____

Required of students in Health Occupations programs.
Refer to College Catalog.

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Name ____________________

Phone ____________________

PERSONAL PHYSICIAN

Name ____________________

Phone ____________________

I hereby give permission to release information on this health form to my specific program faculty including fieldwork faculty and Health division administration.

Yes ______ No ______

____
Student's Signature

Please mail completed form to:

MADISON AREA TECHNICAL COLLEGE
Health, Human & Protective Services Division
3550 Anderson Street
Madison, WI 53704

Phone: (608) 246-6065 / 246-6014
(800) 322-6282, ext.6065 or 6014
Fax: (608) 246-6013

STUDENTS: PLEASE DO NOT WRITE ON THIS SIDE

TO THE HEALTH CARE PROVIDER:

This examination and form is to be completed within three months prior to the opening of classes. The following information is needed for all health services students. All programs have agreements with affiliating clinical agencies which require verification of compliance with the employee health standards.

YOUR COOPERATION IN COMPLETING THIS FORM IN ITS ENTIRETY WILL BE BENEFICIAL TO ALL CONCERNED, THANK YOU.

PATIENT INFORMATION

Name ______________________________

Program of Study ______________________________

MANDATORY TESTS AND IMMUNIZATIONS

Must have written evidence of two M.M.R. Immunizations one or more months apart. (Students who have had the disease must have titers drawn for mumps, measles, and rubella — please attach lab reports.

Immunizations	Date
M.M.R. 1	
M.M.R. 2	

Varicella (chicken pox):
must have varicella titer or two varicella immunizations.

Varicella Immunization #1 _______(*date*) #2 _______(*date*)

Varicella Titer: attach lab report

TB SKIN TEST or TB X-RAY 2 step skin test is required within last 6 months	Date Given	Date Read	Pos	Neg
1st TB SKIN TEST				
2nd TB SKIN TEST				
TB X-RAY				

Two-step TB skin test is not required for those who have documented evidence of current annual screenings. Documented evidence must include current year's screening and the past two years' documentation.

Dates of Annual TB skin test: __________ current year __________ 1st past year __________ 2nd past year

If TB Skin test is positive, a negative chest x-ray report must be provided. If the chest x-ray is positive, proof of treatment is required.

Tetanus/Diphtheria (required to be within last 10 years)	

HEPATITIS B VACCINE

Immunization for Hepatitis B, is required for the programs listed below[1]. The vaccination is strongly recommended for all other Division programs. Please discuss the immunization and the risks involved with the patient.

Hepatitis B Vaccine	Date
Series 1	
Series 2	
Series 3	

[1] Associate Degree Nursing
Dental Assistant
Dental Hygienist
Medical Assistant
Medical Lab Technician
Occupational Therapy Assistant
Practical Nursing
Radiography
Respiratory Care Practicioner
Surgical Technician

TO THE BEST OF YOUR KNOWLEDGE, HAS THIS PATIENT BEEN TREATED FOR OR HAS SHE/HE TESTED POSITIVE FOR ANY OF THE FOLLOWING:

	Yes	No
Tuberculosis		
Hepatitis A		
Hepatitis B		
Rheumatic Fever		
Heart Disease		
Lifting Restrictions		
Latex Sensitivity		

If yes, please explain for each:

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Do you recommend any special accommodations for this patient based on patient's history or disabilities:

_____ No _____Yes If yes, please attach explanation:

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HEALTH CARE PROVIDER INFORMATION

______________________________ __________
Signature of Person performing the physical examination (Date)

____
Print Name and Title

______________________________ (   )
Clinic or Office Phone

____
Address

____
City State Zip