# 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 | RELATIONSHIP | CHECK EACH ITEM | YES | NO | RELATIONSHIP | CHECK EACH ITEM | YES | NO | RELATIONSHIP |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TUBERCULOSIS | o | o | | HEART TROUBLE | o | o | | EPILEPSY OR CONVULSIONS | o | o | |
| DIABETES | o | o | | CANCER | o | o | | NERVOUS OR MENTAL DISORDER | o | o | |
| HIGH BLOOD PRESSURE/STROKE | o | o | | ASTHMA, HAY FEVER, HIVES | o | o | | BLEEDING/CLOTTING DISORDER | o | o | |

## PERSONAL HEALTH HISTORY

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

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

**IF YES, OR ANY OTHER DISEASE/PROBLEMS, GIVE DETAILS**

| 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.

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 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. Were 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 785-460-5502. If you answer any question YES you MUST go to Student Health**