KEYIN COLLEGE

Grand Falls-Windsor Campus
Telephone: (709) 489-8560
Fax: (709) 489-8565

Funeral Director and Embalmer Program

CONFIDENTIAL
STUDENT MEDICAL HISTORY

Name: _____ _____
First **Last**

Address: _____
Street

_____
City / Town

_____
Postal Code

TELEPHONE: _____ **E-MAIL:**_____

DOB: _____ _____ _____
Year **Month** **Day**

MCP#: _____

Keyin College assumes no financial responsibility for completion of this form and / or necessary diagnostic tests / reports. Please keep a copy of this form for your files.

SECTION A: To be completed by applicant prior to physician assessment

Personal Health History

During your life time (including childhood) have you ever had the following?

	NO	YES	DETAILS
Allergies			
Asthma/HayFever/ Bronchitis/TB			
Chronic Back Condition			
Diabetes			
Epilepsy			
Gastrointestinal Disorders			
Hearing Impairment			
Heart/Circulatory/ Blood Pressure Problems			
Hepatitis			
Kidney Infections/Disease			
Special Needs			
Professional Mental Health Care			
Skin Conditions			
Thyroid			`
Visual (Corrective Lenses or Disease)			

List other communicable diseases: _____

List any operations you have had: _____

List any medications you are currently taking: _____

List any medical conditions not included above: _____

_____

_____

SECTION B: To be completed by applicant

Section B Release of Information (Please sign prior to your physical examination)

I, _____, do hereby consent to have this medical information released to Keyin College.

Signature: _____

Witness: _____

Date: _____

SECTION C: To be completed by physician

A complete physical is not required.

After reviewing this applicant's health history, please complete the following questions:

	(If yes, please specify)	
Does the applicant require future medical consultation?	☐ Yes	☐ No
Is the applicant's physical condition such that participation in athletic/physical activities is restricted?	☐ Yes	☐ No
Has the applicant any physical or emotional health problem/disability which would require any special consideration?	☐ Yes	☐ No

Comments:

_____

_____

_____

_____

Physician's Name: _____

Address: _____

Date: _____

Signature: _____

SECTION D: Communicable Disease / Immunization Record

This record may be obtained from your local Public Health Nurse or by contacting the Department of Health. It is mandatory that all immunizations listed below are completed prior to participating in any fieldwork. It is recommended that all applicants have their immunizations brought up to date prior to admission of their program.

1. Two Step Tuberculin Skin Test (TST). If TST completed greater than one year prior to placement, student must have an updated TST completed.
2. Two MMR (Measles, Mumps and Rubella) vaccines **OR** lab confirmed immunity.
3. Primary series of three doses of a combined Tetanus and Diphtheria (Td) vaccine and documented booster of Td within last ten years.
4. Single dose of Tdap vaccine if not previously received in adulthood (18 yrs of age or older) for protection of Pertussis.
5. All students at risk of exposure to blood and blood contaminated -body fluids should be vaccinated against Hepatitis B and have documented Anti-HBs level of ≥10 IU/L.

1st Step TST	Date:	Result:
2nd Step TST	Date:	Result:
*TST	Date:	Result:
*Chest X-Ray	Date:	Result:
Td *Tdap	Date: Date:	
*Hepatitis B	Date:	
	Date:	
	Date:	
Anti-HBs:	Date:	Result:
MMR	Date:	Date:
*Measles titre	Date:	Result:
*Rubella titre	Date:	Result:
*Mumps titre	Date:	Result:
*Varicella titre	Date:	Result:
*Varicella	Date:	Date:
Influenza	Date:	

***completed if required**

Allergies: _____

Work Accommodations/Modifications: _____

_____

_____

_____

I declare that the information included in this form is accurate and complete to the best of my knowledge and false statements and/or omission of relevant medical information can be grounds for disqualification or dismissal.

_____ _____

Student Signature Date

_____ _____

Health Care Provider Signature Date