Barbados Community College
Health Information Form and Certification of Immunization

PART I: DECLARATION BY APPLICANT
(To be completed by the Applicant)

Please complete and return this form to the Student Affairs Department at registration. Applicants exempted from immunizations should provide an Affidavit, documentation from their medical practitioner or certificate of religious exemption under confidential cover to the Registrar.

Please note, failure to complete and comply with guidelines for the Health Information and Certificate of Immunization Form may result in the applicant being unable to register or the withdrawal of the offer of a place in the programme.

Student ID#________________________________ Barbados National ID # __________________________________

Division/Programme of Study____

Name ____
Last Name *First Name* *Other name(s)*

Date of Birth ___/___/ ___ Sex ☐ M ☐ F Country of Birth ________________ Main Language Spoken ____________
MM / DD / YY

Address ____

____

Name of Parent /Guardian________________________________ Phone _______________ Work or Cell ________________

Name of Emergency Contact 1_____________________________ Phone _______________ Work or Cell ________________

Name of Emergency Contact 2_____________________________ Phone _______________ Work or Cell ________________

MEDICAL QUESTIONNAIRE

1. Have you been diagnosed with a chronic illness? e.g. asthma, cancer, diabetes, epilepsy, hypertension, heart condition, other ?
   ☐ Yes ☐ No
   If so, give details ____
2. Are you taking any medication on a regular basis? ☐ Yes ☐ No
   If so, name the medication ____
3. Has any member of your family or any person living in your household suffered from or been suspected of suffering from tuberculosis?
   If so, give details ____
4. Do you have any of the following conditions for which you may require special accommodation** during your studies?
   a) physical disability (including visual, auditory, neurological, other ___________________________
   b) psychological disorder (mental condition) ____________________________________
   c) learning disability (including dyslexia, attention deficit/ hyperactivity disorder) _________________

If "yes", please f**orward separately under confidential cover to the Registrar the supporting documentation from your professional health provider.**

5. Do you have
   a) allergies to food, medicine or chemicals? ☐ Yes ☐ No
   b) allergies to environmental agents including insects, animal dander, grass? ☐ Yes ☐ No
   c) allergic conditions such as sinusitis, allergic rhinitis, eczema, other? ☐ Yes ☐ No

   If yes, give details ____

   Type of allergic reaction: □ anaphylaxis □ local reaction Response required: □ none □ epi pen □ other: ____________

☐ Check here if you want to discuss confidential information indicated with the Registrar/College Health Care Clinicians or College Counsellors.

Please provide the following information:

	Name	Phone	Date of last Appointment
Primary Care Provider (Family Physician)			
Specialist (Counsellor Psychologist/Psychiatrist/ other)			

Signature of Applicant: ___________________________________ Date ____/_____/____

PART II – CERTIFICATION OF IMMUNIZATION

To be completed and signed by a Medical Examiner

Applicants exempted from immunizations should provide an Affidavit, documentation from their medical practitioner or certificate of religious exemption under confidential cover to the Registrar.

Applicant's Name ____
Last Name *First Name* *Other Name(s)*

IMMUNIZATION HISTORY	RECORD COMPLETE DATES OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis (DTP, DT, DTaP) *Booster within 10 years*	1	2	3	4	5
Poliomyelitis (OPV)	1	2	3	4	5
Measles, Mumps, Rubella (MMR)	1	2			
Varicella	1	2	*Date of Varicella Disease or Serological Confirmation of Varicella Immunity:*		
BCG	1				
Mantoux ***Required for General Nursing & Nursing Assistant Students ONLY***	APPLIED	READ	RESULTS	NURSE/MD SIGNATURE	
Hepatitis B ***Required for Students in the Health Science, Physical Education, Hospitality and Science Divisions***	1	2	3		
*Meningococcal ***Required for International Students ONLY***	1				
Other	1	2	3	4	5

A copy of the applicant's immunization record signed and stamped by a physician indicating the applicant's immunization records will be accepted in lieu of recording the dates in this section.

I certify that this applicant is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements of the National Expanded Programme on Immunizations (EPI) schedule and Barbados' Health Services (Communicable & Notifiable Diseases Regulation) for adolescents and adults.

Signature of Medical Provider or Health Department Official: ____________________________ Date: |____|____|____|
DD MM YY

CONDITIONAL ENROLLMENT:
I certify that this applicant has received at least one dose of each of the vaccines required and has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on ___________________________.

Signature of Medical Provider or Health Department Official: ____________________________ **Date** |____|____|____|
DD MM YY

MEDICAL EXEMPTION: As specified in the Health Services (Communicable & Notifiable Disease Regulation), I certify that administration of the vaccine(s) designated below would be detrimental to this applicant's health.

☐ DPT/DT/Tdap ☐ MMR ☐ Varicella ☐ Hepatitis B

The vaccine(s) is (are) specifically contraindicated because (please specify):

____

____

____

This contraindication is: permanent ☐ or temporary ☐ and expected to preclude immunizations until: ___________________
Date

....
Signature of Medical Provider or Health Department Official **Date**

PART 111 – COMPREHENSIVE PHYSICAL EXAMINATION REPORT
To be completed and signed by a Medical Practitioner

Complete the medical exemption or conditional enrollment section as required

This form is to be completed by a Medical Practitioner who has examined the applicant.

Student's Name: ____ Date of Birth ____/____/____ Sex ☐ M ☐ F

Student Identification #:______________________ Programme of Study____

Health Assessment

Date of Assessment: ____/___/____

Weight: ______ lbs Height: ______ ft _____ in.

Body Mass Index (BMI) _________ BP _________

Urinalysis: colour ____________________________

pH_________ Specific gravity _________

Glucose_______ Ketones ______________

Protein _______ Leucocytes __________

Blood ________ Bile _______________

☐ Age /gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

1 =Within normal 2=Abnormal findings 3=Referred for evaluation or treatment

HEENT 1 2 3	Neurological 1 2 3	Skin 1 2 3
Lungs 1 2 3	Abdomen 1 2 3	Genital 1 2 3
Heart 1 2 3	Extremities 1 2 3	Urinary 1 2 3

Comments: ____
____
____
____

Vision Screen

☐ With corrective Lenses (check if yes)

Stereopsis ☐ Pass ☐ Fail

☐ Not tested

Distance	Both	R	L	
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ Unable to test – needs rescreen

Recommendations to College

Summary of Finding (check one):

☐ **No conditions identified of concern to impact study program**

☐ **Conditions identified that can potentially impact the applicant during their studies or during physical activity.**
(Please complete section below and/or explain here to include any physical disability, mental disability, non-communicable disease –(NCD), evidence of recent infectious disease or allergy):
____
____
____

___ **Individualized Health Care Plan needed** (In the management of NCD or other condition(s)

___ **Medication:** Self-administers prescribed medicine for specific health condition(s)___________________________________
____

Restricted Activity (including that for pregnancy): ____
____

Comments: ____
____
____

Health Care Professional's Certification (Write legibly and affix official stamp):

Full Name: ____

Signature ____

Practice/Clinic Name: ____

Address: ____

Date: ____/____/____