



Natural Gas Technician Certificate Program Medical History and Physical Report

A health form is required for all participants in the Natural Gas Technician Certificate Program.

(Complete pages 1 and 2 before going to your health care provider for physical examination.)

The information requested on this form is for the use of the Administrators of this program and will not be released to anyone without your knowledge and consent except as required by law.

Date: _____ Name: _____

Last

First

Middle

Date of Birth: ____/____/____ Gender (select one): F M Other

Ethnicity origin (or race): Please specify your ethnicity. White/Caucasian Hispanic/Latino Black/African American

Native American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander Other Prefer not to answer

Address: _____ Home Phone: (____) _____

City: _____ State: _____ Zip: _____ County: _____

Email: _____ Cell Phone: (____) _____

In case of emergency contact:

Alternative emergency contact:

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Address: _____

Address: _____

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____

Home Phone: (____) _____

Cell Phone: (____) _____

Cell Phone: (____) _____

Do you have medical insurance? Yes No (if yes, please attach copy of insurance card)

Last Name, First: _____

Medical History

(Complete before going to your physician.)

Family History

	Age	State of Health	Age of Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Spouse/Partner	_____	_____	_____	_____
Child(ren)	_____	_____	_____	_____

Check if any relatives have had any of the following (indicate relationship if checked).

Alcoholism	<input type="checkbox"/>	_____	Gastrointestinal Disease	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	_____
Bleeding Disorders	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____	Kidney Stones/Disease	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____	Mother tool DES	<input type="checkbox"/>	_____
Epilepsy/Seizures	<input type="checkbox"/>	_____	Rheumatoid Arthritis	<input type="checkbox"/>	_____
Emotional Problem/Mental Illness	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	_____

Personal History

Check if you have had any of the following. Comment on all checked conditions in the space below.

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Eating Disorder Anorexia/Bulimia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Nose/Sinus Problem
<input type="checkbox"/> Allergy (Food)	<input type="checkbox"/> Emotional Distress/Problems	<input type="checkbox"/> High/low Blood Pressure	<input type="checkbox"/> Rheumatic or Scarlet Fever
<input type="checkbox"/> Allergy (Environment)	<input type="checkbox"/> Eye Problem	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fungal Disease	<input type="checkbox"/> Intestinal/Stomach Problems	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Gum/Dental Disease	<input type="checkbox"/> Kidney Disease/Infection/Stones	<input type="checkbox"/> Skin Problem
<input type="checkbox"/> Bronchitis/Pneumonia	<input type="checkbox"/> Gynecological Problems	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Speech Disorder
<input type="checkbox"/> Cancer/Tumor/Cyst	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Malaria	<input type="checkbox"/> Surgery
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Throat/Tonsil Problems
<input type="checkbox"/> Ear Trouble/Hearing Loss	<input type="checkbox"/> Herpes	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tuberculosis

List all drug allergies: _____

Have you consulted or been treated by a psychiatrist, clinical psychologist, social worker, or other counselor? Yes No

If yes, explain: _____

Are you taking any medications? Yes No If yes, please list: _____

If you have been hospitalized or have any medical problems, including those indicated above, please explain: _____

Last Name, First: _____

Physical Examination

Height: _____ Weight: _____ BP: _____ Pulse: _____

1. Skin _____
2. Eyes _____
3. Ears _____
4. Nose/Sinuses _____
5. Mouth/Thyroid/Dental _____
6. Neck/Thyroid _____
7. Heart _____
8. Lungs/Chest _____
9. Breasts _____
10. Abdomen _____
11. Nervous System _____
12. Extremities/Joints _____
13. Back _____
14. Genitourinary System _____
15. Emotional/Mental Status _____

Date of physical exam: _____

For females, date of LMP: _____

Vision

Glasses Yes No

Contacts Yes No

Eye Glass Prescription _____

Lab Work

Hemoglobin or Hematocrit (numerical value): _____

Urine: Albumin: _____ Glucose: _____

Mantoux Test for TB (within 1 year)

Date of Test: ____/____/____

Date of Reading: ____/____/____

Results in millimeters: _____

If Mantoux is positive (>10mm):

Date of chest x-ray: ____/____/____

Results: Positive Negative

If recent converter or chest x-ray positive, explain treatment

Please list all allergies: _____

EKG was done and is within normal limits. (Attach copy)

Please comment on any abnormal condition the patient has had or is being treated for:

Last Name, First: _____

Immunization Requirements

New York State law, in keeping with recommendations of the American College Health Association and the Centers for Disease Control, require all students born on or after January 1, 1957 who are attending an institution of higher education to show proof of two doses of live measles vaccine, one dose of live mumps vaccine and one dose of live rubella vaccine, given after one year of age. In lieu of immunization dates, the physician may provide a date of disease for measles and mumps only; history of rubella disease is not acceptable. Student may also choose to have blood tests called titers in lieu of immunizations which will show actual levels of immunity to each of the three diseases. If titers are drawn, please attach copies of actual laboratory reports.

	Date	Date	Date	Date of Disease	Titer Date and Results
					Attach actual lab report
MMR					
MEASLES					
MUMPS					
RUBELLA					
RECOMMENDED HEPATITIS-B					
RECOMMENDED VARICELLA					
TETANUS-DIPHTHERIA (within 10 years)					
RECOMMENDED MENINGOCOCCAL					

This is the medical approval for students who are planning on participating in the Natural Gas Technician Certificate Program.

Be aware that students in this program will have to demonstrate the necessary physical ability and stamina involved in a variety of tasks including, but not limited to lifting up to 90 pounds, bending, shoveling and the operation and handling of various pneumatic hand tools.

Student is fully cleared to participate in the Natural Gas Technician Certificate Program.

Attested to:

Doctor's Signature: _____

Print Name: _____

Address: _____

Phone: (____) _____

Fax: (____) _____

Date: ____/____/____

Prior to registration return the completed forms to:
 Kingsborough Community College
 Continuing Education Registration Office
 2001 Oriental Blvd., Room T8-206
 Brooklyn, New York 11235

This form remains valid for one year from the date of physician signature, or until medical status changes.

Office Stamp: