GCC
GUAM COMMUNITY COLLEGE
Kulehon Kumunidåt Guåhan

SCHOOL OF TECHNOLOGY & STUDENT SERVICES
Health Service Center
Telephone: (671) 735-5586/644 Fax: (671)734-8830

EMERGENCY & HEALTH INFORMATION

THIS INFORMATION IS CONFIDENTIAL

Legal Name: _____ Student ID Number: _____
Last First MI

Mailing Address: _____ Date of Birth: _____

Home Address: _____ Gender: ( )Male ( )Female

In case of an ACCIDENT OR SUDDEN ILLNESS, it is necessary that we have the following information to facilitate communication.

LIST THREE (3) PEOPLE WE CAN CONTACT IN CASE OF AN EMERGENCY.

NAME	PLACE OF WORK	HOME PHONE	WORK	PAGER/ CELL
NAME	PLACE OF WORK	HOME PHONE	WORK	PAGER/ CELL
NAME	PLACE OF WORK	HOME PHONE	WORK	PAGER/ CELL

MEDICAL INFORMATION
Do you have any of the following conditions?

Asthma	[ ]Yes	[ ] No	Hearing Problems	[ ] Yes	[ ] No
High/ Low Blood Pressure	[ ] Yes	[ ] No	Do you wear a hearing aid?	[ ] Yes	[ ] No
Diabetes	[ ] Yes	[ ] No	Vision Problems	[ ] Yes	[ ] No
Heart Disease	[ ] Yes	[ ] No	Check the appropriate vision apparatus (is used)		
Epilepsy (Seizures)	[ ] Yes	[ ] No	Wear contact lenses	[ ] Yes	[ ] No
Severe Allergies	[ ] Yes	[ ] No	Wear glasses	[ ] Yes	[ ] No

Other health conditions not on the above list: _____
Allergy (specify to what substances): _____
Medication (list the name): _____
Serious illness or injury (include the year): _____
Physical or emotional limitations: _____

HEALTH CARE PROVIDER INFORMATION:
Name of Family Doctor: _____ Phone Number: _____ Other Number:_____
Type of Health Insurance: _____ Clinic services at: _____
Hospital you will be sent too in case of an emergency: [ ]GMHA [ ]Naval Hospital

I, the undersigned, do hereby authorize GCC personnel to contact directly the persons named on this form, and do authorize the Health Staff to render treatment as deemed necessary in an emergency. I also authorize the GCC personnel to provide the referred health agency the necessary information regarding illness or injury.

_____ _____
STUDENT'S SIGNATURE (If minor, PARENT'S SIGNATURE DATE

REVISED FEB 2007

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STEPS TO GETTING YOUR STUDENT HEALTH CLEARANCE

Please read carefully and follow procedures.

FOR NEW STUDENTS

I. Please make sure that you have completed the Student Information Form (01 Form) and have the information inputted into the school system at the **Admissions & Registration Office.**

II. Complete the Emergency & Health Information Sheet.

III. The Student Health Center requires the following documents:
   a. Completed and signed Emergency and Health Information Sheet
   b. Annual TB clearance
   c. A dose of Tetanus and Diphtheria (TD) vaccine – done within 10 years and;
   d. At least one does of Measles, Mump, and Rubella (MMR) vaccine if born in 1957 or later.

   NOTE: If your choice of study will place you at risk for exposure to blood borne pathogens, you are advised to follow further instructions of your respective program advisor regarding other health requirements such as Hepatitis B vaccine and physical examination.

IV, Upon submission of completed documents and updating the computer systems, the Health Center will sign the registration form (Add/Drop Form) and will clear you to proceed to register.

FOR CONTINUING / RETURNING STUDENTS

I. Once you have filled out your registration form (Add/Drop Form) and obtained your advisor's initials, you may proceed to register for the classes. However, if your health data is determined to be incomplete, the Admissions & Registration Office personnel will direct you to see the School Health Counselor before registering for the current semester.

II. Upon submission of the updated required documents at the Health Center, you may return to the Admissions & Registration to continue the registration process.

For any questions, please contact the school health counselor(s).

CECILIA H. DELOS SANTOS, R.N.
School Health Counselor

GLYNIS ALMONTE, R.N.
School Health Counselor

WILLIAM MELENDEZ, JR.
Student Support Administrator, C.A.C.

Revised Feb 2007

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GCC TUBERCULOSIS SCREENING FORM

LEGAL NAME: _____ DOB:_____
Last First MI Day/Month/Year

STUDENT ID NUMBER: _____ WORK LOCATION: _____

Please check one that applies to you. ( )Employee ( )Student

Rationale: For employees: Section 25103, Title 10 of the Guam Code Annotated requires that all individuals working in a public or private educational institution submit annually a copy of the TB test result and be declared free of communicable disease.

For students: Public law 22-130 mandates all students to provide the school official a copy of the TB test result. The law also requires that a student with a positive test result obtain a Certificate of Tuberculosis Evaluation from the Department of Public Health & Social Services (DPHSS).

Direction: Thoroughly read the following items and do what is in dictated by them. You may be required to proceed to the next item. Items shown below must be completed by a physician, physician's assistant (PA), nurse practitioner (NP), or nurse; refer to each item for specifics.

1. Start with item 2 if you never had a TB test before; or the previous test result was negative. If you have had a history of positive TB test, you do not need to have another TB test administered. You may proceed to item 4.

2. The TB skin test can be administered by a School Health Counselor at the Health Services Center. If a student is a minor, a parent or a guardian has to accompany the student or a parental consent has to be provided in writing. You will be instructed to return to the Health Center within 48-72 hours for the reading. If more than 72 hours have elapsed and you failed to have the test read, the test must be repeated and you may be charged twice on the health fee.

3. Have the School Health Counselor complete item 3 after skin test reading. If the skin test result is negative, you should be done once item 3 is completed. If you r skin test result is positive, after item 3 you should proceed to item 4. Have a health care provider complete item 4. If you are a student, you must obtain follow-up for positive TB skin test at DPHSS. For an employee, you may seek follow up at DPHSS or a private physician.

The repeat of a TB skin test, if a client fails to show up for a scheduled reading, and the interpretation of TB Skin test reading will be based on the protocol established by TB section of DPHSS.

Public Law 22-130 requires that any individual entering from an area other than the U.S. states or territories must have the test conducted within 6 months prior to enrollment.

Has the client been a resident of the U.S. or any of its territories within 6 months prior to this TB test administration?

Yes _____ No_____ If no, where did you reside?_____

Date administered: _____ Date Read _____ Result _____mm.

_____ _____ _____
Name of Physician/PA/NP/Nurse (Print) Signature of Physician/PA/NP/Nurse Date Official Stamp

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4. If patient has not had a chest X-ray, the health provider may need to order one. Have the following completed by an MD, PA, or NP, and b) attach an official radiology report.

a) Is X-ray result suggestive of TB? Yes_____ No_____

b) Date the X-ray was administered: _____

c) Does the person have any of the following:

i) chronic cough (2 weeks duration or longer); Yes_____ No_____

ii) chronic cough with sputum ; Yes_____ No_____

If yes, color of sputum _____

iii) coughing blood; Yes_____ No_____

iv) persistent night sweats; Yes_____ No_____

v) involuntary weight loss and; Yes_____ No_____

vi) unexplained fevers; Yes_____ No_____

d) Is patient currently o n INH preventative therapy? Yes_____ No_____

If not, please state reasons:

_____ patient refuses INH therapy offered

_____ patient over 35 years of age with no risk factor

_____ patient referred to DPHSS for possible INH therapy

_____ patient referred to DP HSS for possible active TB

Other_____

e) _____ Patient, who is an employee, is cleared to return to work.

_____ Patient, who is a student, is cleared for school.

_____ Patient, who is a positive reactor, needs to bring official X-ray report from DPHSS and obtain certificate of TB evaluation form.

_____	_____	_____
Name of Physician/PA/NP/Nurse (Print)	Signature of Physician/PA/NP/Nurse	Date Official Stamp

5. If you had the skin test done at a private health care provider and the reading is negative, proceed to the GCC Health Center and submit the skin test result.

6. If the result of the skin test is positive, submit the Certificate of TB Evaluation Form to the GCC Health Center for clearance.

Checklist for GCC Health Center:

_____ Date this form to indicate when the required documentation was received.

Cleared by the School Health Counselor:

_____	_____	_____
Full Name of Clearing Person	Full Signature of Clearing Person	Date

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