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:

Name: _____

Relationship: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: (_____) _____

Cell Phone: (_____) _____

Alternative emergency contact:

Name: _____

Relationship: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Home 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	☐	Gastrointestinal Disease	☐
Asthma	☐	Heart Disease	☐
Bleeding Disorders	☐	High Blood Pressure	☐
Cancer	☐	Kidney Stones/Disease	☐
Diabetes	☐	Mother tool DES	☐
Epilepsy/Seizures	☐	Rheumatoid Arthritis	☐
Emotional Problem/Mental Illness	☐	Tuberculosis	☐

Personal History

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

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

RENEWABLE ENERGY & SUSTAINABILITY CENTER
Ms. Anna Godas
Lupton Hall (room 138)
At Farmingdale State College
235 Broadhollow Rd
Farmingdale, NY 11735

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

Office Stamp:

Renewable Energy & Sustainability Center at Farmingdale State College