Carteret Community College
Massage Therapy Program Application

Semester Requested (Check One): ☐Fall ☐ Sum ☐ Spring Year: _____

Please Type or Print Clearly

1. Name: _____ _____

_____

First Name MI Last Name

2. Mailing Address _____

City, State, County _____ _____ _____

3. Telephone: Cell_____Home_____

4. Email Address: _____

5. Birthdate_____ **SSN:** _____-_____-_____

6. Sex: ☐Female ☐ Male

7. Ethnicity: ☐ Hispanic Latino ☐ Non-Hispanic Latino ☐Non-Resident Alien ☐ Mexican ☐Puerto Rican

8. Race: ☐ White ☐ Black ☐Indian ☐ Hispanic ☐Asian ☐ Other

9. Highest Grade Completed: ☐GED ☐ Adult/High School Diploma ☐1 Year Vocational Diploma ☐ Associate Degree ☐Bachelor's Degree ☐ Master's Degree +

10. Employment: ☐Unemployed ☐Retired ☐Full Time ☐Part Time **(Employer):**_____

11. Military Status: ☐Active (Branch)_____☐Retired ☐Active Duty Dependent

Signature:_____ **Date:**

_____

For Internal Use Only-Please Do Not Write Below This Line

☐ Medical Form

☐ Birth Certificate

☐ Transcripts (GED, High School, and/or college)

☐ TABE Score_____

☐ CPR/BLS Valid Through_____

☐ Professional Behavior/Attend. Contract

☐ Student Enrollment Agreement

☐ Drug Screen/Background Check

☐ Received 2 documented professional Massages from an NC Licensed Massage Therapist

☐ Fees Paid

Carteret Community College

Student Medical Form
Massage Therapy

Full Name (print): _____ Date Submitted: _____

ID# (or SS#): _____

DO NOT SEPARATE THESE FORMS

It is very important that you read and follow all directions in this packet.
Make sure all information is complete before turning in your packet.
Partial packets *will not* be accepted. Thank you.

PLEASE MAKE A COPY OF THESE FORMS FOR YOUR RECORDS.

Notice: Admission and/or continued enrollment of a student in a Health Sciences program is contingent upon documentation of physical and emotional health.

1. Hepatitis B Vaccine
    a. The vaccine is recommended but not required for Therapeutic Massage students.
2. DTP or Td (Tetanus)
3. Polio
4. MMR
5. Varicella (Chicken Pox)
6. TST (Tuberculin)

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT: The immunization requirements must be met in order to participate in the clinical portion of a Health Sciences program.

Acceptable Records of Your Immunizations May Be Obtained from Any of The Following: (Be certain that your name, date of birth, and ID Number appear on each sheet and that all forms remain together. The records must be in black ink and the date of vaccine administration must include the month, day, and year. **KEEP A COPY FOR YOUR RECORDS**.)

- High School Transcripts – These **may** contain some, but not all of your immunization information. Contact your high school for these records if needed for immunization purposes.
- Personal Shot Records – Must be verified by a physician's stamp or signature, or by a clinic or health department stamp
- Local Health Department
- Military Records or WHO (World Health Organization Documents)
- Previous College or University – **Your immunization records do not transfer automatically. You must request a copy**

Note: Gather all your immunization records and discuss them with your healthcare provider. You may need to obtain additional immunizations and/or titers. Discuss requirements with your individual program faculty early to avoid delays.

GUIDELINES:	IMMUNIZATION REQUIREMENTS ACCORDING TO AGE	Note 1-4 footnote explanations		
STUDENTS 17 YEARS OF AGE AND YOUNGER				
DTP or Td[1]	Polio	Measles[2/3]	Mumps[2/3]	Rubella[3/4]
3	3	2	2	1
STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER				
DTP or Td[1]	Polio	Measles[2/3]	Mumps[2/3]	Rubella[3/4]
3	0	2	2	1
STUDENTS BORN BEFORE 1957				
DTP or Td[1]	Polio	Measles	Mumps	Rubella[4]
3	0	0	0	0

[1]DTP or Tdap (Diphtheria, Tetanus, Pertussis), Td (Tetanus, Diphtheria): One Tdap booster within the last ten years.
[2]Measles: One dose on or after 12 months of age; second dose at least 28 days later. Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age.
[3]Only laboratory proof of immunity to rubella, measles or mumps disease is acceptable if the vaccine is not taken. History of rubella, measles or mumps disease, even from a physician, is not acceptable. Attach Lab report.
[4]Nonpregnant women of childbearing age who could become pregnant should be vaccinated with MMR vaccine, or have evidence of rubella immunity.

IMMUNIZATION RECORD – (To Be Completed If Immunization Record is not submitted)
(Please print in black ink). To be completed and signed by a physician or clinic. A complete immunization record from a physician or clinic may be attached to this form. Students may be denied clinical privileges for refusing required immunizations, which may result in dismissal from the program.

Last Name	First Name	Middle Initial	Date of Birth (mo/day/year)	ID or SS#

REQUIRED IMMUNIZATIONS				
	mo/day/year	mo/day/year	mo/day/year	mo/day/year
DTP or Td	(#1)	(#2)	(#3)	(#4)
Td booster				
T-dap				
Polio				
MMR (on/after age 12 months)				
MR (on/after 12 months)				
Measles (on/after age 12 months)			(Disease Date NOT Accepted) - - - - - - - - - - - - - - - - - - -	Titer Date, Result, Documentation
Mumps			(Disease Date NOT Accepted) - - - - - - - - - - - - - - - - - - -	Titer Date, Result, Documentation
Rubella			(Disease Date NOT Accepted) - - - - - - - - - - - - - - - - - - -	Titer Date, Result, Documentation
Varicella (chicken pox) series of two doses or immunity by positive blood titer		(#1)	(#2) (Disease Date NOT Accepted)	Titer Date, Result, Documentation
Tuberculin (TST) Test within 12 months or risk assessment / symptom screening (questionnaire) completed. If you have not had a TST annually, or your risk assessment / symptom screening indicates otherwise, a two-step TST is required. ----------OR---------- If the prior TST is positive, a chest x-ray is required (or documentation of screening *annually* on Department of Health and Human Services "Result of TB Screening").		Date read:	(1)	(2)
		mm induration:		
		Date:		
		Results:		
Flu Vaccine – Clinical facilities may require students to wear a mask during clinical rotations or refuse the student a clinical experience if the student has not had the flu vaccine.		mo/day/year	Medical Waiver if Applicable: - Documentation Attached	
Hepatitis B series ----------OR---------- Hepatitis A/B combination series	mo/day/year	mo/day/year	mo/day/year	Titer Date, Result, Documentation Medical Waiver - if Applicable: - Documentation Attached

Signature or Clinic Stamp REQUIRED:

_____ _____
Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____
Print of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

_____
Office Address **City** **State** **Zip Code**

PHYSICAL EXAMINATION BY MEDICAL PRACTITIONER
Please print in black ink – Complete all of the following:

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	ID or SS#

Height _____ Weight _____ TPR _____ / _____ / _____ BP _____ / _____

VISION:	**HEARING:**
Corrected Right 20/ _____ Left 20/ _____	(gross) Right _____ Left _____
Uncorrected Right 20/ _____ Left 20/ _____	15 ft. Right _____ Left _____
Color Vision _____	

A. Is there loss or seriously impaired function of any single or paired organs? Yes _____ No _____
Explain: _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain treatment/medication: _____

C. Recommendation for physical activity (during patient care activities) Unlimited_____ Limited _____
Describe limitation: _____

Based on my assessment of this student's physical and emotional health on _____ (date), he/she appears to be able to participate in the activities of a health profession in a clinical setting and provide safe care to the public. YES _____ NO _____
If no, please explain
_____
_____

Signature of Primary Care Physician / Physician Assistant / Nurse Practitioner **Date**

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

Office Address **City** **State** **Zip Code**

TO BE COMPLETED BY STUDENT (Please print in black ink)

Last Name (print) First Name Middle/Maiden Name SS#* email address

Permanent Mailing Address City State Zip Area Code/Phone Number

Date of Birth (mo/day/yr) _____ Gender _____ M _____ F Marital Status _____ S _____ M _____ Other

Insurance Information:

Hospital/Health Insurance (Name and Address of Company) Area Code/Telephone Number

Name of Policy Holder Social Security Number Employer

Policy or Certificate Number Group Number Is this an HMO/PPO/Managed Care Plan _____ Yes _____ No

Emergency Contact Information:

Name of Person to Contact in Case of Emergency Relationship

Address City State Zip Area Code/Telephone Number