Student Medical Form

Coastal Carolina Community College

Nursing and Allied Health Programs

Name _____

Program_____

Date_____

Instructions for Completion of the Student Medical Form

The information provided in this health form by the student and the health care provider is confidential and protected by the Health Insurance Portability and Accountability Act Privacy Rule.

1. The student must complete and sign the Personal and Family History prior to the physical exam.
2. The student should complete as much as possible of the Immunization Record prior to the exam and must provide the school with documentation of any immunizations, titers, or screening tests done prior to the current physical exam. If new immunizations, blood tests, or screening tests are done during the physical exam visit, the health care provider must document and initial those and sign the immunization summary.
3. Students who are providing titers showing immunity in lieu of a vaccination record must submit the laboratory result documenting the titer.
4. The health care provider must complete and sign the physical exam form.

Additional Requirements for Dental, Surgical Tech, Medical Lab Technician, and Emergency Medical Technician students

- Surgical Tech and Dental students require a vision exam including a fundascopic exam.
- Medical Lab Technician students require a color vision test
- Emergency Medical Science (EMS) students require fitting for a HEPA mask (performed by EMS faculty).
- Dental students will as need to complete a dental examination.
- Dental, EMS, MLT, and Surg Tech students are required to complete the vaccines and titer for MMR, Varicella, and Hepatitis B.

Instructions regarding immunizations and health screening tests

In order to protect both you and your patients, our clinical agencies require the following immunizations and health screening tests. In order to attend clinical rotations, you must provide ***all*** of the required information unless you have a documented medical contraindication.

Use the following checklist to confirm that you have provided all required information regarding immunizations and health screening tests. Check specific program requirements to determine if both the vaccines and titer are required.

_____ **Measles, mumps, rubella (MMR)**

Unless you were born before 1957, you must provide the following:

- Two MMR vaccinations after your first birthday
  OR
- Titers showing immunity to each of the three disorders

_____ **Varicella**

- Two varicella vaccines

OR

- Titer showing immunity

OR

- Documentation of chicken pox disease from the physician who diagnosed and treated it

_____**Tetanus/diphtheria/pertussis (Tdap) booster**

- You must have a documented tetanus booster within the past 10 years.

_____ **Tuberculosis screening**

- You must have documented TB screening within the past 12 months.
- If you have no history of positive screening, you must have a PPD placed and read within 48-72 hours **OR** a Quantiferon Gold or T-spot blood test.
- If you have had a positive screening, you must show documentation of
    - A chest X-ray

      OR
    - Negative Sputum test

_____ **Hepatitis B**

- A series of 3 hepatitis B immunizations

  AND
- A titer showing immunity
- If you have completed a series of 3 vaccines and are still non-immune, you are required to:
    - Repeat the series of 3 hepatitis B vaccinations **AND**
    - Obtain a titer 4 to 6 weeks after that vaccine
- If you are still non-immune you may:
    - Obtain two more vaccines to complete a second series of 3, which may be followed in 4 to 6 weeks by a titer. (The CDC cites a significant increase in seroconversion when this option is chosen, but seroconversion is not 100%.)

    - If you are unable to convert to a positive immunity or have a medical documented reason you may sign a waiver saying that you do not wish to have more vaccines and understand that you may be susceptible to hepatitis B.
- Since the series and titers take an extended period of time, you may be in process of completing the series when clinical begin. Provide all documentation that you have. Your Department Head will give you interim instructions.
- Dental students must have the first 2 vaccines completed prior to starting clinical.

Influenza

- Influenza immunization is not part of your fall admission requirements, but you will be required to receive the vaccine annually during the flu season unless you have a documented medical contraindication or religious objection.

Personal and Family Health History

Name _____

The following two pages are be completed by student prior to the physical exam.

Last name _____ **First name**_____ **Middle initial**_____

Date of Birth _____ **Social Security # (optional)** _____

Gender _____ **Marital Status** _____

Address _____

Preferred Phone _____

Emergency Contact and Phone_____

.....

Are you allergic to any medications? If so, what medications, and what was your reaction? _____

_____

_____

Check any illness or medical conditions that you have had:

___ high blood pressure
___ rheumatic fever
___ heart disease
___ asthma
___ other lung disorder
___cancer
___ malaria
___ thyroid disorder
___ diabetes
___ allergies
___ arthritis
___ frequent headaches
___ severe head injury
___ autoimmune disorder
___ disabling depression
___ anxiety
___ gastrointestinal disorder
___ hepatitis
___ hernia
___ fatigue
___ anemia
___ vision or eye disorder
___ recurrent back pain
___ neck or back injury
___ kidney infection
___ hearing loss
___ sexually transmitted infection
___ blood transfusion

Provide details about any items checked. Attach an additional sheet if necessary.

_____

_____

_____

Do you smoke? ____ How many cigarettes/day? ____ Drink alcohol? _____ How many drinks/wk? ____

List all medications you take regularly.

_____

_____

_____

Has any person related to you by blood had any illness or condition below? If so, check the condition and state the relationship of the family member to you.

___ high blood pressure _____
___ stroke _____
___ heart disease _____
___ blood disorder _____
___ high cholesterol _____
___ diabetes _____
___ glaucoma _____
___ cancer _____
___ substance abuse _____
___ psychiatric illness _____

Do you have any conditions that limit or interfere with performing physical activity?

Have you ever been hospitalized? Specify when and why.

Have you received treatment for a psychiatric, emotional, or behavioral disorder?

Do you have any vision problems not corrected with glasses or contact lenses or any hearing impairment?

Have you seen a physician in the past six months for anything other than routine well visits?

Have you had any serious injuries or illnesses not already noted?

Statement: I have personally supplied the above information and attest that it is accurate and true to the best of my knowledge.

Signature of student _____ Date _____

Printed name of student _____

Immunization Record

Name _____

The student should complete as much as possible of the Immunization Record prior to the exam and must provide documentation of any prior immunizations, titers, or screening tests.

If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

The Coastal Carolina Community College Nursing and Allied Health Division assume responsibility for following up on any incomplete records of required immunizations that cannot be verified by the health care provider.

Required immunizations

	Date	Date	Date	Date
DTP or Td (Initial series)	___/___/___	___/___/___	___/___/___	___/___/___
Tdap booster (most recent)	___/___/___			
MMR (2 after 1st birthday)	___/___/___	___/___/___		
MMR booster(s)	___/___/___	___/___/__		
Varicella (2)	___/___/___	___/___/___		
Hepatitis B (initial series)	___/___/___	___/___/___	___/___/___	
Hepatitis B repeat series (if not immune)	___/___/___	___/___/__	___/___/___	

Titers (where indicated)

	Date	Result
Rubeola (measles) titer	___/___/___	
Mumps titer	___/___/___	
Rubella titer	___/___/___	
MMR titer (booster)	___/___/___	
Varicella titer	___/___/___	
Hepatitis B titer #1* (after original series)	___/___/___	**mIU/mL***
Hepatits B titer # 2 * (after repeat of series)	___/___/___	**mIU/mL***

***A quantitative hepatitis B titer result is required for Dental students.**

Tuberculosis screening (most recent) ***Either PPD or TB blood testing is acceptable for health occupation students.***

	Date	Interpretation
PPD Placed	___/___/___	**N/A**
PPD Read (pos or neg) **OR**	___/___/___	
Quantiferon Gold or T-Spot (pos, neg, or indeterminate)	___/___/___	

OR

Screening following positive PPD history (most recent)

	Date	Result
Chest X-ray (pos or neg)	___/___/___	
Record of TB screening (attach form and indicate low risk or high risk)	___/___/___	

If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

_____ _____

Signature of physician, nurse practitioner, or physician's assistant **Date**

_____

Print Name of Health Care Provider

Physical Examination

Name _____

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

	Normal	Abnormal	Description or Comments
Head, ears, nose, throat			
Eyes			
Respiratory system			
Cardiovascular system			
Gastrointestinal system			
Abdomen			
Genitourinary system			
Musculoskeletal system			
Endocrine system			
Neurological system			
Skin			
Mental health status			

Is the student under treatment for any medical condition? If yes, provide brief details of disorder and treatment.

Are there currently any limits on the student's physical activity? How long will these limits apply?

Examiner's Statement: **Based on my assessment of this student's physical and mental health, at this time s/he appears to be able to participate in the activities of a health profession in a clinical setting. _____ Yes _____ No**
Comments:

_____ _____

Signature of physician, nurse practitioner, or physician's assistant **Date**

_____ _____

Print Name of Health Care Provider **Area Code and Phone**

_____

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