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
  o A chest X-ray
  OR
  o 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:
    o Repeat the series of 3 hepatitis B vaccinations AND
    o Obtain a titer 4 to 6 weeks after that vaccine
  - If you are still non-immune you may:
    o 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%.)
    o 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

The following two pages are to 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  ___ disabling depression
___ rheumatic fever  ___ anxiety
___ heart disease  ___ gastrointestinal disorder
___ asthma  ___ hepatitis
___ other lung disorder  ___ hernia
___ cancer  ___ fatigue
___ malaria  ___ anemia
___ thyroid disorder  ___ vision or eye disorder
___ diabetes  ___ recurrent back pain
___ allergies  ___ neck or back injury
___ arthritis  ___ kidney infection
___ frequent headaches  ___ hearing loss
___ severe head injury  ___ sexually transmitted infection
___ autoimmune disorder  ___ 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 ___________________________ __diabetes ___________________________
___ stroke _______________________________ __glaucoma __________________________
___ heart disease ________________________ __cancer ______________________________
___ blood disorder ________________________ __substance abuse ______________________
___ high cholesterol _____________________ __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

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<tr>
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<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
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<tbody>
<tr>
<td>DTP or Td (Initial series)</td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
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<tr>
<td>Tdap booster (most recent)</td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
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<tr>
<td>MMR (2 after 1st birthday)</td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
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<tr>
<td>MMR booster(s)</td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
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<tr>
<td>Varicella (2)</td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
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<tr>
<td>Hepatitis B (initial series)</td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
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<tr>
<td>Hepatitis B repeat series (if not immune)</td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
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### Titers (where indicated)

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Result</th>
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<tbody>
<tr>
<td>Rubeola (measles) titer</td>
<td><em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Mumps titer</td>
<td><em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Rubella titer</td>
<td><em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>MMR titer (booster)</td>
<td><em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Varicella titer</td>
<td><em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B titer #1* (after original series)</td>
<td><em><strong>/</strong></em></td>
<td>mlU/mL*</td>
</tr>
<tr>
<td>Hepatitis B titer # 2* (after repeat of series)</td>
<td><em><strong>/</strong></em></td>
<td>mlU/mL*</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD Placed</td>
<td><em><strong>/</strong></em></td>
<td>N/A</td>
</tr>
<tr>
<td>PPD Read (pos or neg) OR</td>
<td><em><strong>/</strong></em></td>
<td></td>
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<tr>
<td>Quantiferon Gold or T-Spot (pos, neg, or indeterminate)</td>
<td><em><strong>/</strong></em></td>
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</table>

OR

Screening following positive PPD history (most recent)

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Result</th>
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<tbody>
<tr>
<td>Chest X-ray (pos or neg)</td>
<td><em><strong>/</strong></em></td>
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<tr>
<td>Record of TB screening (attach form and indicate low risk or high risk)</td>
<td><em><strong>/</strong></em></td>
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</table>

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 _______________________________________

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<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
<th>Description or Comments</th>
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<tbody>
<tr>
<td>Head, ears, nose, throat</td>
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<tr>
<td>Eyes</td>
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<tr>
<td>Respiratory system</td>
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<tr>
<td>Cardiovascular system</td>
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<td>Gastrointestinal system</td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Genitourinary system</td>
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<tr>
<td>Musculoskeletal system</td>
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<tr>
<td>Endocrine system</td>
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<tr>
<td>Neurological system</td>
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<tr>
<td>Skin</td>
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<td></td>
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<tr>
<td>Mental health status</td>
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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