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. Students claiming a disease history in lieu of any vaccinations and titers must provide the record from the medical facility where the disease was originally diagnosed and treated.
5. The health care provider must complete and sign the physical exam form.

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

- Surgical tech students require a vision exam including a fundascopic exam
- Medical lab technician students require a color vision test
- Emergency medical technician students require fitting for a HEPA mask.

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.

_____ 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

Continued on the next page
Tetanus/diphtheria (TD) or adult tetanus/diphtheria/pertussis (Tdap)
- 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 there is no previous TB screening documented, a 2 Step Test (TST) is required.
- If you have no history of positive screening, you must have a PPD placed and read within 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 The current North Carolina Department of Health and Human Services recommended screening for previous positive PPD signed by a health care provider

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 Get a fourth hepatitis vaccine AND
    o Obtain a titer 4 to 6 weeks after that vaccine
  - If you are still non-immune you may:
    o Sign a waiver saying that you do not wish to have more vaccines and understand that you may be susceptible to hepatitis B
    OR
    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%.)
- Since the series and titers take an extended period of time, you may be mid-process when clinicals begin. Provide all documentation that you have. Your Department Head will give you interim instructions.

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. Declination of influenza may result in inability to participate and complete clinical requirements. You will be informed of the appropriate time to receive this vaccination.
Personal and Family Health History

Name ____________________________

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 # (last 4 digits) _______________________________
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
___ hemia
___ 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 your 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

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 assumes responsibility for following up on any incomplete records of required immunizations that cannot be verified by the health care provider.

<table>
<thead>
<tr>
<th>Required immunizations</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<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>Td or 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) or titer</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>
</tr>
<tr>
<td>Varicella (2) or titer</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>
</tr>
<tr>
<td>Hepatitis B (initial series) titer required</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>
</tr>
<tr>
<td>Hepatitis B booster (if nonimm) titer required</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>
</tr>
<tr>
<td>Hepatitis B (optional 2 to complete 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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</tbody>
</table>

<table>
<thead>
<tr>
<th>Titers (where indicated)</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubeola (measles)</td>
<td><em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td><em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td><em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>Varicella</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 single booster)</td>
<td><em><strong>/</strong></em></td>
<td>mlU/mL*</td>
</tr>
<tr>
<td>Hepatitis B titer #3* (after second series of 3) Optional</td>
<td><em><strong>/</strong></em></td>
<td>mlU/mL*</td>
</tr>
</tbody>
</table>

* A quantitative hepatitis B titer result is required.

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

<table>
<thead>
<tr>
<th>PPD Placed</th>
<th>Date</th>
<th>Date (TST)</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em><strong>/</strong></em></td>
<td><em><strong>/</strong></em></td>
<td>N/A</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PPD Read (pos or neg) OR Quantiferon Gold or T-Spot (pos, neg, or indeterminate)</th>
<th>Date</th>
<th>Date</th>
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</table>

OR

Screening following positive PPD history (most recent)

<table>
<thead>
<tr>
<th>Chest X-ray (pos or neg)</th>
<th>Date</th>
<th>Result</th>
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<tbody>
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<td></td>
<td><em><strong>/</strong></em></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Record of TB screening (attach form and indicate low risk or high risk)</th>
<th>Date</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><em><strong>/</strong></em></td>
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</tbody>
</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** _________________________________

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

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