Student Medical Form

Coastal Carolina Community College

Nursing and Allied Health Programs

Student 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 the immunization requirements 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, 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 Dental

- Dental and Surgical tech students require a vision exam including a fundascopic exam
- Medical lab technician students require a color vision test

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 (Surg Tech will need a Positive titer for clinical requirements).

_____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. The 2-Step must be completed within the recommended timeframe of 4 weeks.
- 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
    - A chest X-ray
      OR
    - 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 (Dental Programs require a quantitative result)
- If you have completed a series of 3 vaccines and are still non-immune, you are required to:
    - Get a fourth hepatitis vaccine **AND**
    - Obtain a titer 4 to 6 weeks after that vaccine
- If you are still non-immune 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

      OR
    - 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.

COVID-19

- The COVID-19 vaccination is required by the hospitals for participation in clinical requirements. The hospital will have the final decision for if any exemptions are approved. If the exemption is denied the student will not be able to participate in clinical activities therefore unable to meet all program requirements.

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 # (last 4 digits) _____

Gender _____

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 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

Name _____

The student should complete the Immunization Record prior to the exam and provide documentation of any prior immunizations, titers, or screening tests to support the previous immunizations.

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.

Required immunizations

	Date	Date	Date	Date
DTP or Td (Initial series)	___/___/___	___/___/___	___/___/___	___/___/___
Td or Tdap booster (most recent)	___/___/___			
MMR (2 after 1st birthday) **or titer**	___/___/___	___/___/___		
Varicella (2) **or titer**	___/___/___	___/___/___		
Hepatitis B (initial series) **titer required**	___/___/___	___/___/___	___/___/___	
Hepatitis B booster (if nonimm) **titer required**	___/___/___			
Hepatitis B (optional 2 to complete series)	___/___/___	___/___/___		
COVID-19 date & type	____/___/___	___/___/___	___/___/__	___/___/__

Titers (where indicated)

	Date	Result
Rubeola (measles)	___/___/___	
Mumps	___/___/___	
Rubella	___/___/___	
Varicella	___/___/___	
Hepatitis B titer #1* (after original series)	___/___/___	**mIU/mL***
Hepatits B titer # 2 * (after single booster)	___/___/___	**mIU/mL***
Hepatitis B titer #3 * (after second series of 3) **Optional**	___/___/___	**mIU/mL***

***A quantitative hepatitis B titer result is required.**

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

	Date	Date (TST)	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**