

# **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 fundoscopic 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 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 \_\_\_\_\_

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:

- |  |   |
|--|---|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> disabling depression           |
| <input type="checkbox"/> rheumatic fever     | <input type="checkbox"/> anxiety                        |
| <input type="checkbox"/> heart disease       | <input type="checkbox"/> gastrointestinal disorder      |
| <input type="checkbox"/> asthma              | <input type="checkbox"/> hepatitis                      |
| <input type="checkbox"/> other lung disorder | <input type="checkbox"/> hernia                         |
| <input type="checkbox"/> cancer              | <input type="checkbox"/> fatigue                        |
| <input type="checkbox"/> malaria             | <input type="checkbox"/> anemia                         |
| <input type="checkbox"/> thyroid disorder    | <input type="checkbox"/> vision or eye disorder         |
| <input type="checkbox"/> diabetes            | <input type="checkbox"/> recurrent back pain            |
| <input type="checkbox"/> allergies           | <input type="checkbox"/> neck or back injury            |
| <input type="checkbox"/> arthritis           | <input type="checkbox"/> kidney infection               |
| <input type="checkbox"/> frequent headaches  | <input type="checkbox"/> hearing loss                   |
| <input type="checkbox"/> severe head injury  | <input type="checkbox"/> sexually transmitted infection |
| <input type="checkbox"/> autoimmune disorder | <input type="checkbox"/> 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.

<input type="checkbox"/> high blood pressure _____	<input type="checkbox"/> diabetes _____
<input type="checkbox"/> stroke _____	<input type="checkbox"/> glaucoma _____
<input type="checkbox"/> heart disease _____	<input type="checkbox"/> cancer _____
<input type="checkbox"/> blood disorder _____	<input type="checkbox"/> substance abuse _____
<input type="checkbox"/> high cholesterol _____	<input type="checkbox"/> 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
<b>DTP or Td</b> (Initial series)	___/___/___	___/___/___	___/___/___	___/___/___
<b>Td or Tdap booster</b> (most recent)	___/___/___			
<b>MMR</b> (2 after 1 <sup>st</sup> birthday) <b>or titer</b>	___/___/___	___/___/___		
<b>Varicella</b> (2) <b>or titer</b>	___/___/___	___/___/___		
<b>Hepatitis B</b> (initial series) <b>titer required</b>	___/___/___	___/___/___	___/___/___	
<b>Hepatitis B booster</b> (if nonimm) <b>titer required</b>	___/___/___			
<b>Hepatitis B</b> (optional 2 to complete series)	___/___/___	___/___/___		
<b>COVID-19 date &amp; type</b>	___/___/___	___/___/___	___/___/___	___/___/___

## Titers (where indicated)

	Date	Result
<b>Rubeola (measles)</b>	___/___/___	
<b>Mumps</b>	___/___/___	
<b>Rubella</b>	___/___/___	
<b>Varicella</b>	___/___/___	
<b>Hepatitis B titer #1*</b> (after original series)	___/___/___	mIU/mL*
<b>Hepatitis B titer # 2 *</b> (after single booster)	___/___/___	mIU/mL*
<b>Hepatitis B titer #3 *</b> (after second series of 3) <b>Optional</b>	___/___/___	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
<b>PPD Placed</b>	___/___/___	___/___/___	N/A
<b>PPD Read</b> ( pos or neg) <b>OR</b>	___/___/___	___/___/___	
<b>QuantiFERON Gold or T-Spot</b> (pos, neg, or indeterminate)	___/___/___		

**OR**

**Screening following positive PPD history** (most recent)

	Date	Result
<b>Chest X-ray</b> (pos or neg)	___/___/___	
<b>Record of TB screening</b> (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