BROWARD COLLEGE
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BROWARD COLLEGE HEALTH SCIENCE PROGRAMS
MEDICAL HISTORY & PHYSICAL EXAMINATION

In order to participate in the clinical portion of any health science program, the student must complete a Medical History and Physical Examination Form. Required documentation, should be current, within the last year, and must be attached to the form. Admission into any of the Health Science programs is provisionally based upon acceptance of the approved health evaluation record.

Be certain to take all documentation of immunizations with you to your physical examination so that the form can be completed correctly. Failure to submit the original form - complete with documentation - may prevent you from progressing to the clinical portion of the program. Valid verification of immunizations is required for eligibility to attend clinicals at health care agencies.

To assist the student and the Health Care Examiner - MD, DO, nurse practitioner (ARNP) or physician assistant (PA) in completing this form, instructions are provided below. **Students are responsible for the cost of the physical examination and any related expenses. This health evaluation must be submitted no later than the specified campus due dates.**

Section 1	**Student Self-Report of Medical History:** *This section must be fully completed legibly by the student prior to having a physical examination.*
Section 2a 2b 2c	• **Section 2a: Medical History and Physical Examination** • **Section 2b: Immunization Verification** • **Section 2c: Health Care Examiner's Statement** *This section is to be completed by a Licensed Professional Health Care Examiner (MD, DO, ARNP and PA only). All sections must be completed with a signature provided.* The Health Care Examiner will review any documentation the student provides. As related to tuberculosis screening, the student is required to have a two-step PPD or a chest X ray or the Quantiferon TB Gold Blood Test yearly. A tetanus shot is required within 10 years of the date of the examination. The examiner will also order a titer to determine the presence or absence of immunity to rubella, rubeola, varicella and hepatitis. In the event that a titer does not indicate immunity, the student must then present proof of vaccination dated after the titer was completed. *A student stating that they have had the disease is NOT acceptable documentation.* In addition, a seasonal flu vaccine is required with documentation. All sections of the Immunization Verification section must be completed by the medical provider. Copies of titer results and supporting documentation must be attached to the completed physical
Sections 3 4 5	• **Section 3: Release of Information** • **Section 4: Verification of Compliance with Technical Performance Standards** • **Section 5: Permission to Render Medical Treatment** *This section must be reviewed and signed by the student.*

Please submit the completed form – pages 2 through 6 – with all required documentation to the Admissions office or to the Program Manager as directed.

Prior to submitting the form, be sure to make a copy of the form and any supporting documentation for your own records.

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SECTION 1	Student Self-Report of Medical History

IMPORTANT Student Instructions:

Complete this page in its entirety prior to meeting with the examiner who is completing your physical exam. Please be sure to print all answers neatly.

Last Name	**First Name**	**Student ID**	
Address	**City**	**State**	**Zip**
Home Phone	**Work Phone**	**Cell**	
Emergency Contact Name	**Relationship**	**Contact at this number:**	
BC Email Address			

Review of Systems / Medical History — please check all that apply			
Abnormal Bleeding		Hernia	
Allergies		High Blood Pressure	
Anemia		High Cholesterol	
Anxiety		Intestinal / Stomach Trouble	
Arthritis		Low Back Condition / Scoliosis	
Asthma		Mental Disorder	
Cancer of		Mononucleosis	
Chest Pain		Neck Condition	
Chronic Cough		Neurological Disorder	
Concussion / Head Injury		Orthopedic Disorder	
Depression		Prior Surgery	
Diabetes		Rheumatic Fever	
Ear Trouble / Hard of Hearing		Seizure Disorder	
Eating Disorder		Sickle Cell Trait	
Eye Trouble / Vision Loss		Sinus Problems	
Fracture of _____		Skin Disease	
Gallbladder Disease		Splenectomy	
Headaches / Migraines		Sprain of _____	
Heart Murmur or Arrhythmia		Syncope / Fainting	
Heart Problems (other)		Thyroid Disease	
Hepatitis		Tuberculosis	

For ALL boxes checked above, please provide additional details, including the current status.

_____

_____

_____

Please describe any other current health concerns:

_____

_____

_____

Allergies: ____ None _____ Latex ____ Penicillin/Ampicillin ____
Other (List)_____

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SECTION 2a	Medical History and Physical Examination

IMPORTANT Examiner Instructions:

Please examine this student as you would for a routine check-up. This student will be working closely with people in various health care settings. Please indicate/comment on any abnormal findings, using additional sheets if necessary for providing further documentation.

Please fill this page out completely – failure to do so may result in student being unable to attend clinicals.

HEIGHT: _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____

SYSTEM	NORMAL	FINDING	COMMENTS/PREVIOUS CONDITIONS/SURGERY
Cardiovascular			
Endocrine/Metabolic			
Eyes/Ears/Nose /Throat			
Gastrointestinal			
Genitourinary			
Integumentary			
Musculoskeletal			
Neurological			
Respiratory			

Examiner: Summarize diagnosis, treatment and prognosis or provide any official documentation as it relates to any "yes" answer.

Is the student under treatment for any medical, surgical or mental disorder? **YES** **NO**
If yes, please provide details:

Is the student now taking any medications? **YES** **NO**
If yes, please list:

Does the student require any follow-up health supervision? **YES** **NO**
If yes, please specify:

Within the last 5 years, has the student been treated for any substance related (drug/alcohol) disorder? **YES** **NO**
If yes, please specify:

Is the student limited from participating in physical activities in the clinical area? **YES** **NO**
If yes, please specify limitations:

SECTION 2b **Immunization Verification**

Tuberculin Test	**Documentation**: Supporting documentation of PPD within last 365 days		
PPD Test Date:	**Result:**	*Attach copy of PPD result*	
If the result of the tuberculin test is + or if student is restricted from a PPD due to the HCG vaccine, either a Chest X-Ray or the Quantiferon TB Gold Blood Test is required (within last 365 days)			
Chest X-Ray date**:**	**Result:**	*Attach copy of X-ray report*	**Examiner's Initials/Date**
Quantiferon TB Gold **date:**	**Result:**	*Attach laboratory results*	

Tetanus/Diphtheria	**Requirement**: Vaccination required within last 10 years		
Vaccination Date:		*Attach copy of proof of vaccination*	**Examiner's Initials/Date**

Flu Vaccination	**Requirement**: Annual Vaccination seasonally between September 15 – March 31		
Vaccination Date:		*Attach copy of proof of vaccination*	**Examiner's Initials/Date**

Declination of Flu Vaccination

Declination: I decline the Flu Vaccination at this time. I understand that by refusing to take this vaccination, I may be at risk of acquiring the flu. I also understand that by declining the flu vaccination, it may impact my ability to participate in clinical practicums or internships.

STUDENT SIGNATURE: _____

Rubella/Rubeola/Mumps	**Requirement**: Documented vaccination within last 365 days OR proof of positive titer			
Titer Date:		**Please √**	*Attach laboratory results*	**Examiner's Initials/Date**
	Immune			
	Not Immune			
Vaccination Date: (if negative titer) **2 doses of MMR 4 weeks apart**	**1st Dose:**		*Attach copy of proof of vaccination*	
	2nd Dose:			

Varicella	**Requirement**: Documented vaccination within last 365 days OR proof of positive titer. Student statement of previous exposure is NOT considered to be proof of immunity.			
Titer Date:		**Please √**	*Attach laboratory results* *Attach copy of proof of positive titer*	**Examiner's Initials/Date**
	Immune			
	Not Immune			
Vaccination Date: (if negative titer) **2 doses 4 weeks apart**	**1st Dose:**		*Attach copy of proof of vaccination*	
	2nd Dose:			

Hepatitis B	**Requirement**: Documented vaccination in last 365 days OR proof of + titer OR Declination				
Titer Date:		**Please √**	*Attach laboratory results*	**Examiner's Initials/Date**	
	Immune				
	Not Immune				
Vaccination Dates: (if negative titer)	#1 now	#2 in 1 month	#3 5 months after #2	*Attach copy of proof of vaccination*	

Declination of Hepatitis B Vaccination

Declination: I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B vaccination at this time. I understand that by refusing to take this vaccination, I continue to be at risk of acquiring Hepatitis B. I also understand that by declining to take the Hepatitis B vaccination may impact my ability to participate in clinical practicums or internships.

STUDENT SIGNATURE: _____

SECTION 2c	**Health Care Examiner's Statement**	
I have verified that the individual I have examined is the individual on this form and that the above tests/vaccinations were performed in this office/laboratory or I have reviewed any documentation relative to the student's immunization record.		
Examiner's Name (Printed):		
Examiner's Signature:		
License #:	Phone #:	Date:

SECTION 3	**Release of Information**

In conformance with 20 U.S.C. 123g (Family Education Rights and Privacy Act) and Section 228.093, Florida Statutes, I authorize Broward College and its agents to release and disclose the information contained in this form, including my immunization record, upon request, to a clinical affiliation site

_____ I herein give permission to duplicate the requested information and release it to the clinical site.

_____ I do not give permission to duplicate the requested information and release it to the clinical site. I understand this may impact my ability to participate in clinical practicums or internships.

Student Signature: _____ **Date:** _____

SECTION 4	Verification of Compliance with Technical Performance Standards

The Health Science Education has outlined specific Technical Performance Standards that serve to inform students of skills and/or physical/psychological demands necessary for program completion and workplace responsibilities. After review of the Technical Performance Standards for my program of study which are available for review on the program's website:

_____ I have determined that I will be able to perform the standards or essential skills listed.

_____ I have determined that I will be able to perform the standards or essential skills listed but will require reasonable accommodation. I have registered with Disability Services and will arrange to meet with the Program Manager to determine the accommodation necessary.

Student Signature: _____ **Date:** _____

SECTION 5	Permission to Render Medical Treatment

In case of serious illness or accident, I give Broward College or its representative(s) permission to secure medical and/or surgical care to include transportation to a physician or hospital of their choice, examination, medication, and surgery that is considered necessary for my good health. I understand that I am responsible for any cost incurred if not covered by the Health Care Agency Affiliation Contract or by the Health Science accident insurance.

Student Signature: _____ **Date:** _____

Respiratory Care
Technical Performance Standards

The technical performance standards of the Health Science programs outline the expectations and abilities considered essential for student success relative to achieving the level of competency required for graduation and for a career in the field of respiratory care. Potential students should carefully review all of the standards as detailed below.

Data Collection Standards

• Tactile ability sufficient for collection and assessment of data such as pulse, temperature, texture, size, shape, muscle tone. Ability to adjust settings on equipment as needed.
• Auditory ability sufficient to monitor and assess health care needs including but not limited to hearing monitor alarms, emergency signals, evaluate breath sounds and heart sounds, and verbal communication as when a patient/client calls for assistance
• Olfactory ability sufficient for patient/client assessment as in determining typical odors related to infectious agents.
• Visual ability sufficient for assessing and observing the patient/client and environment including near and far acuity, depth perception, visual fields, and other characteristics of objects.

Communication Standards

• Possess sufficient communication skills to interact effectively with others verbally, non-verbally and in written form demonstrating sensitivity to individual and cultural differences
• Ability to express self verbally in a language that will be understood by a majority of patients/clients
• Ability to explain interventions, provide patient/client education, and assess/relate patient/client response to interventions
• Possess the ability to recognize, interpret and respond to non-verbal cues from patients/clients, self and others

Working Conditions

• There is frequent exposure to blood and body fluids from patients as well as the potential for exposure to air borne pathogens.
• Must be able to perform in frequent stressful situations.
• Must be able to deal with conflict resolution and must have effective confrontational skills.

Sensorimotor Standards

• The respiratory care practitioner is required to pull and push heavy objects as well as assist in moving patients to and from stretchers, wheelchairs, or beds. They are required to position patients and assist in lifting, moving and restraining patients.
• The practitioner is required to stand and walk for extended periods of time and must be able to bend, stoop, kneel and run.
• Fine motor abilities: Must be able to write documentation of patient care/assessment
• Reaching: Must be able to extend the arms and hands in all directions.
• Handling: Must be able to seize, hold, rotate, and control objects with the hands.
• Fingering: Must be able to pick up with fingers.
• Feeling: must be able to perceive such attributes of objects and materials as size, shape, temperature or texture by means of receptors in the skin; particularly those of the fingertips.

Intellectual and Conceptual Standards

- Ability to assimilate, within a reasonable amount of time, large amounts of complex, technical and detailed information from a variety of sources
- Ability to identify cause-effect relationship in order to make judgments and set priorities in clinical situations
- Recognize physiological changes in patient/client status and act appropriately
- Ability to prioritize multiple tasks, integrate information and make decisions promptly

Behavioral and Social Standards

- Possess sufficient interpersonal skills to establish meaningful and effective rapport with patients/clients, families, and colleagues from a variety of different social, emotional, economic, cultural, ethnic, religious and intellectual backgrounds as well as within all age groups
- Ability to cope with heavy workload schedule and patient demands
- Function effectively during periods of high stress
- Display adaptability
- Accept responsibility for own behavior
- Engage in self-assessment activities which includes identification of learning needs

Ethical Standards

- Exhibit a respect for truth and a commitment to honesty in all didactic and clinical pursuits
- Adhere to ethical and legal guidelines established by applicable national organizations and governmental agencies
- Abide by all institutional regulations.
- Appreciate and respect patient/family confidentiality.