



Broward College

Medical History and Physical Examination Form



In order to participate in the clinical portion of any health science program, the student must complete a Medical History and Physical Examination form. Documentation, such as lab results must be attached to the form.

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 your program.

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.**

Section 1:

Student Self-Report of Medical History

This section, wherein information about past and current health status is detailed, should be completed by the student **prior** to having a physical examination. **Be sure to include the name of the program on each of the pages of the form.**

Section 2:

Physical Examination

Laboratory Findings and Immunization Verification

Health Care Examiner's Statement

This section is to be completed by the 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 and tetanus. He/she 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 immunity dated after the titer was completed (if medically cleared). **Students stating that they have had the disease is NOT acceptable documentation.**

In order to be considered immune, the student must meet the criteria indicated below.

Tuberculosis

- ✓ Documentation of PPD skin test results indicating negative reactivity reported within three months of the physical examination **or**
- ✓ Evidence of a chest x-ray within three months of the physical examination and medical treatment for those with positive reactivity or past history of positive reactivity.

Tetanus and Diphtheria

- ✓ Documentation of vaccination or booster within last 10 years.

Rubella (German Measles)

- ✓ Titer results provided as laboratory evidence of immunity with the titer results attached.
- ✓ Documentation of immunization if indicated as per titer results. The immunization must be administered after the titer was completed (if medically cleared).

Rubeola (Measles)

- ✓ Born before December 31, 1956 **or**
- ✓ Titer results provided as laboratory evidence of immunity with the titer results attached.
- ✓ Documentation of immunization if indicated as per titer results. The immunization must be administered after the titer was completed (if medically cleared).

Varicella (Chickenpox)

- ✓ Born before December 31, 1956 **or**
- ✓ Titer results provided as laboratory evidence of immunity with the titer results attached.
- ✓ Documentation of immunization if indicated as per titer results. The immunization must be administered after the titer was completed (if medically cleared).

Hepatitis B (HBV)

- ✓ Documentation of antibody testing revealing immunity to Hepatitis B with results attached **or**
- ✓ Documentation of a series of three doses of vaccine if no immunity was indicated on the titer. The series must be administered after the titer was completed **or**
- ✓ Documentation of Hepatitis B vaccination series in progress with completion of the series **prior** to the start of clinical rotations. The series must be started after the titer was completed **or**
- ✓ Declination statement signed by the student.

Section 3:

Release of Information

This section must be reviewed and signed by the student.

Section 4:

Permission to Render Medical Treatment

This section must be reviewed and signed by the student.

Section 5:

Verification of Compliance with Technical Performance Standards

This section must be reviewed and signed by the student.

Section 6:

Student Statement

This section must be reviewed and signed by the student.

Submit the completed form – pages 1 through 4 – with all required documentation submitted to the appropriate program representative.

Prior to submitting the form, please make copies for your own records.



**BROWARD COLLEGE
HEALTH SCIENCE EDUCATION
MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM**



Student Self Report of Medical History

Last Name	First Name	ID #	
Address	City	State	Zip
Home Phone #	Work Phone #	Cell or beeper #	
Emergency Contact Name	Relationship	Contact at:	
BC Email Address		Program Enrolled:	

Review of Systems / Medical History — please check all that apply

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

MANTOUX PPD – TUBERCULIN TEST – REQUIRED ANNUALLY

Test Date: _____	Attach results of laboratory test
If result of tuberculin test is positive, a chest X-ray is required	
Chest X-ray Date: _____	Attach results

Please indicate any health concerns, if any, that you presently have:

Drug Allergies/Medicine Sensitivity/Latex Allergy

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Penicillin, Ampicillin |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Other _____ |

Information detailed on the Medical History and Physical Examination form is legally privileged and confidential. It is intended for use by the Health Science program unless written consent has been provided for release to other parties.

Medical History and Physical Examination

Examiner: 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 or providing further documentation.

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

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

Is the student under treatment for any medical, surgical or emotional condition? **YES** **NO**

If yes, please provide details:

Is the student now taking any medications? **YES** **NO**

If yes, please list:

Can student participate in unlimited physical activities in the clinical area? **YES** **NO**

If no, please specify limitations:

Does the student require any follow-up health supervision? **YES** **NO**

If yes, please specify:

EXAMINER'S NAME (PLEASE PRINT) _____	PHONE _____
ADDRESS _____ CITY _____	STATE _____ ZIP _____
SIGNATURE OF MD/DO/ARNP _____	DATE _____
LICENSE # _____	

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Immunization Verification

Examiner Instructions: To verify immunity, check the appropriate box indicating method of verification utilized or that a titer has been completed or that vaccination has been provided. **Attach results** of laboratory tests as indicated and any document if required.

Mantoux PPD – Tuberculin Test – required annually

Test Date:	Attach results of laboratory test
<i>If result of tuberculin test is positive, a chest X-ray is required.</i>	
Chest X-ray Date:	Attach results

Tetanus/ Diphtheria – required within last 10 years

<input type="checkbox"/>	To verify previous vaccination, attach documentation via a medical record or examiner's statement.	
<input type="checkbox"/>	Vaccination Provided	Date:

Rubella – German Measles

*If a rubella vaccination can be documented via a medical record or examiner's statement, a new vaccination is not required.
If unable to document vaccination, student must have a Rubella titer to verify immunity or a current vaccination.*

<input type="checkbox"/>	To verify previous vaccination, attach documentation via a medical record or examiner's statement.	
<input type="checkbox"/>	Titer Completed - Date:	Attach results of laboratory test
	If Positive Titer	No vaccination required, immunity verified
	If Negative Titer	Vaccination Provided Date:
<input type="checkbox"/>	Vaccination Provided without Titer	Date:

Rubeola – Measles

If born on or after January 1, 1957, student must have proof of receiving two MMR or MR vaccines after 1 year of age OR establish immunity through titer OR have a current vaccination.

<input type="checkbox"/>	To verify previous vaccination attach documentation via a medical record or examiner's statement.	
<input type="checkbox"/>	Titer Completed - Date:	Attach results of laboratory test
	If Positive Titer	No vaccination required, immunity verified
	If Negative Titer	Vaccination Provided Date:
<input type="checkbox"/>	Vaccination Provided without Titer	Date:

Varicella - Chickenpox

Student statement of previous exposure IS NOT considered to be proof of immunity

<input type="checkbox"/>	Titer Completed - Date:	Attach results of laboratory test
	If Positive Titer	No vaccination required, immunity verified
	If Negative Titer	Vaccination Provided Date:
<input type="checkbox"/>	Vaccination Provided without Titer	Date:

Hepatitis B - Required

<input type="checkbox"/>	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.			
	Student Signature required:		Date:	
<input type="checkbox"/>	Verification of previous vaccination	Titer Date:	Results:	
<input type="checkbox"/>	Vaccination Provider	Injection 1 Date:	Injection 2 Date:	Injection 3 Date:

I certify that the above tests/vaccinations were performed in his office/laboratory or I have reviewed any document relative to the student's immunization record.

SIGNATURE OF MD/DO/ARNP _____

DATE: _____

EXAMINER'S NAME (PLEASE PRINT) _____

LICENSE # _____

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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.

Student Signature: _____

Date: _____

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:

____ 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 Associate Dean to determine the accommodation necessary.

Student Signature: _____

Date: _____

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: _____

Notarization of Form – to be signed in presence of Notary Public

I acknowledge that the information provided in this form is accurate to the best of my knowledge. My signature below indicates review and compliance with all of the statement above:

Student Signature _____

State of Florida County of _____

The foregoing instrument was acknowledged before me this _____ day _____, 20_____

By _____

Notary Public – State of Florida

STAMP

Personally known _____ or produced identification _____ Type of ID _____

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