In order to participate in the clinical portion of any health science program, the student must complete a Medical History and Physical Examination Form. Admission into a Health Science Program is provisionally based upon acceptance of the approved health evaluation record.

Failure to submit the original form - complete with documentation - may prevent the student from progressing to the clinical portion of the program. Valid verification of immunizations is required for eligibility to attend clinical rotations at the health care agencies.

Students are responsible for the cost of the physical examination and any related expenses.

Section 1: Student Self-Report of Medical History
This section about past and current health status should be completed by the student prior to having the physical examination.

Section 2: Medical History and Physical Examination
The Health Care Examiner will review any documentation the student provides.

Immunization Verification
I. A PPD and/or CXR required annually, within the past 12 months. The PPD result must be documented in millimeters of induration. If a PPD is positive, a chest x ray is required every year.

II. A Tdap (Tetanus, Diphtheria, and Pertussis) vaccine is required within 10 years of the date of the examination.

III. A seasonal flu vaccine is required with documentation during flu season.

IV. Measles, Mumps, Rubella, and Varicella titers must be completed to verify immunity. Titers must be completed within 10 years of the date of the examination. All negative results necessitate a vaccination. In the event of a negative Varicella, evidence of one post-titer booster is required. If the Measles, Mumps, or Rubella titer negative, two post-titer MMR boosters are required. A student stating that they have had the disease is NOT acceptable documentation.

V. Hepatitis B titer must be completed within ten years OR the Hepatitis series must be completed (0, 1 month, 2 months after the second dose – 6 months after if using the combined Hepatitis A & B vaccine) OR the student can decline.

VI. Results of all laboratory blood tests and diagnostics are required.

VII. Examiner must initial after completing each section.

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 following sections must be reviewed and signed by the student:

Section 3: Release of Information
Section 4: Verification of Compliance with Technical Performance Standards
Section 5: Permission to Render Medical Treatment

Submit the completed form – pages 2 through 5 – with all required documentation to the Admission Office. Prior to submitting the form, please make copies for your own records.

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.
Section 1: Student Self Report of Medical History – Please Print

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Student ID</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Emergency Contact Name</th>
<th>Relationship</th>
<th>Contact at:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>BC Email Address</th>
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</tbody>
</table>

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

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

Provide information regarding any of the boxes checked above. Explain medical/psychological occurrence and current status.

__________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________

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

__________________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________________

Allergies: _____None  _____Latex  _____Penicillin/Ampicillin  _____Other_________________
Section 2: Medical History & Physical Examination

Examiner: Please examine this student as you would for a routine check-up. This student will be working closely with clients 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: ____________

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>NORMAL</th>
<th>FINDING</th>
<th>COMMENTS/PREVIOUS CONDITIONS/SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine/Metabolic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/Ears/Nose/Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Integumentary</td>
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<td></td>
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<tr>
<td>Musculoskeletal</td>
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<td></td>
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<tr>
<td>Neurological</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
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<td></td>
</tr>
</tbody>
</table>

Examiner: Summarize diagnosis, treatment and prognosis or provide any official documentation as it relates to any written response.

Is the student currently taking any medications?  
YES  NO

If yes, please list:

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

If no, please specify limitation:

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 substance related (drug/alcohol) disorder?  
YES  NO

If yes, please specify:

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Mantoux PPD – Tuberculin Test and/or CXR required annually – within past 12 months

<table>
<thead>
<tr>
<th>PPD Test Date:</th>
<th>Attach results of laboratory test</th>
</tr>
</thead>
</table>

If the result of the tuberculin test is positive or if restricted from a PPD due to the BCG vaccine, a chest X-ray is then required.

<table>
<thead>
<tr>
<th>Date &amp; Time Administered</th>
<th>Administered by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacture of PPD:</td>
<td>Expiration Date:</td>
</tr>
<tr>
<td>Date &amp; Time Read:</td>
<td>Read By:</td>
</tr>
<tr>
<td>Results in Millimeters of Induration:</td>
<td></td>
</tr>
</tbody>
</table>

**IF RESULTS ARE POSITIVE, COMPLETE BELOW:**

<table>
<thead>
<tr>
<th>TST Date:</th>
<th>Results (In Millimeters of Induration)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Medication Started:</td>
<td>Date Completed:</td>
</tr>
<tr>
<td>Chest X-ray Date:</td>
<td>Attach results</td>
</tr>
</tbody>
</table>

Examiner’s Initials / Date

**Tdap Tetanus, Diphtheria, Pertussis – required within the last 10 years**

To verify vaccination, attach supporting documentation via a medical record or examiner’s statement.

Vaccination Provided: Date | Examiner’s Initials/Date

**Flu Vaccine - required seasonally between September 15 & March 31**

Attach supporting documentation via a medical record or examiner’s statement indicating the flu season of vaccination

Season of flu immunization: | Examiner’s Initials / Date

**Rubeola – Measles – required within the last 10 years**

<table>
<thead>
<tr>
<th>Titer Completed - Date:</th>
<th>Attach results of laboratory test</th>
<th>Examiner’s Initials/Date</th>
</tr>
</thead>
</table>

**Mumps – Parotitis - required within the last 10 years**

<table>
<thead>
<tr>
<th>Titer Completed - Date:</th>
<th>Attach results of laboratory test</th>
<th>Examiner’s Initials/Date</th>
</tr>
</thead>
</table>

**Rubella – German Measles – required within the last 10 years**

<table>
<thead>
<tr>
<th>Titer Completed - Date:</th>
<th>Attach results of laboratory test</th>
<th>Examiner’s Initials/Date</th>
</tr>
</thead>
</table>

**Required MMR Boosters for Negative Titors**

<table>
<thead>
<tr>
<th>#1 Booster completed - Date</th>
<th>Examiner’s Initials/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>#2 Booster completed - Date</td>
<td>Examiner’s Initials/Date</td>
</tr>
</tbody>
</table>

**Varicella – Chickenpox – required within the last 10 years**

<table>
<thead>
<tr>
<th>Booster completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Titer Completed - Date:</td>
</tr>
</tbody>
</table>

**Hepatitis B Titer - within the last 10 years**

<table>
<thead>
<tr>
<th>Booster completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Titer completed - Date:</td>
</tr>
</tbody>
</table>

**Hepatitis Series – within 20 years**

<table>
<thead>
<tr>
<th>Booster completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 Booster completed - Date</td>
</tr>
<tr>
<td>#2 Booster completed - Date</td>
</tr>
<tr>
<td>#3 Booster completed - Date</td>
</tr>
</tbody>
</table>

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:

**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: (Please Print) ____________________________________________

Signature of Health Care Examiner: __________________________________________

License # __________________ Phone: ___________________________ Date: ____________________

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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.

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 (ATTACHED):

____ 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: _________________

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: _________________

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.
Technical Performance Standards
Health Information Technology Program

The technical performance standards of the Health Information Technology program outlines the expectations and abilities considered essential for student success relative to achieving the level of competency required for graduation. Potential students should carefully review all of the standards as detailed below.

**Critical Thinking:** Ability sufficient for clinical judgment and to assimilate, within a reasonable time, large amounts of complex, technical and detailed information from a variety of sources.

**Conceptual:** Ability to function during stressful situations; ability to prioritize multiple tasks, integrate information and make decisions; ability to cope with heavy production schedules; display adaptability; accept responsibility for own behavior.

**Interpersonal:** Abilities to interact with healthcare professionals, patients, and groups from a variety of cultural and intellectual backgrounds.

**Communication:** Ability to communicate with healthcare professionals face to face and remotely depending on the setting. Ability to interact effectively with others verbally, non-verbally and in written form. Also, the ability to express oneself verbally in a language that will be understood by a majority of individuals is necessary.

**Mobility:** Physical abilities sufficient to move from place to place and maneuver in small places including ability to balance on a two-step ladder/stool. Carrying, reaching, and lifting files of 10lbs is frequently required. Moving medical data (paper records) from one location to another is possible only through the stooping, kneeling and reaching.

**Motor Skills:** Gross and fine motor abilities sufficient to perform data entry, keyboarding, and handle paper records, both large and small. Electronic data entry is frequently required.

**Hearing:** Auditory ability sufficient to communicate. Responding to physicians, coworkers and other healthcare providers through hearing is necessary in the transmission of patient information.

**Visual:** Ability sufficient for observation, data entry, and comprehension of three-dimensional relationships and spatial relationships of objects.

**Tactile:** Ability sufficient for filing, accessing appropriate codes from paper-based records and electronic records.

**Ethics:** Respect the rights and dignity of all individuals by promoting and protecting the confidentiality and security of health information.