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 the Nursing 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 clinicals at the health care agencies.

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

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**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. QuantiFERON TB Gold Test is not accepted.

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, 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. If the Measles, Mumps, Rubella or Varicella titer is negative, two post-titer MMR or Varicella boosters are required. **A student stating that they have had the disease is NOT acceptable documentation**

V. Hepatitis B titer must be completed within the past ten years. If negative, 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 or 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 nursing office.
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>
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<tbody>
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<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell</th>
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<table>
<thead>
<tr>
<th>Emergency Contact Name</th>
<th>Relationship</th>
<th>Contact at:</th>
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<table>
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<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.

<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>
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<td></td>
<td></td>
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<tr>
<td>Endocrine/Metabolic</td>
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<tr>
<td>Eyes/Ears/Nose/Throat</td>
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<tr>
<td>Gastrointestinal</td>
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<tr>
<td>Genitourinary</td>
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<tr>
<td>Integumentary</td>
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<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Neurological</td>
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<td></td>
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<tr>
<td>Respiratory</td>
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</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?  
If yes, please list: **YES**  **NO**

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

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

Within the last 5 years, has the student been treated for substance related (drug/alcohol) disorder?  
If yes, please specify:  
**YES**  **NO**
**Mantoux PPD – Tuberculin Test and/or CXR required annually – within past 12 months**

<table>
<thead>
<tr>
<th>PPD Test Date</th>
<th>Attach supporting documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date &amp; Time Administered</td>
<td>Administered by</td>
</tr>
<tr>
<td>Manufacture of PPD</td>
<td>Expiration Date</td>
</tr>
<tr>
<td>Date Read</td>
<td>Read By</td>
</tr>
</tbody>
</table>

**Results in Millimeters of Induration**

If results are positive or restricted from a PPD due to the BCG vaccine, a chest X-ray is required

| Chest X-ray Date | Attach Results of Chest X-ray | Examiner’s Initials |

**Tdap (Tetanus, Diphtheria, Pertussis) – within 10 years**

| Date Vaccination Provided | Attach supporting documentation | Examiner’s Initials |

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

| Date of Vaccine | Injection Site | Attach supporting documentation |
| Lot Number | Expiration | Examiner’s Initials |

**MMR - Rubeola(Measles), Mumps(Parotitis), Rubella(German Measles) within 10 years**

| Date Titer Completed | Attach supporting documentation | Examiner’s Initials and date |
| #1 Date Booster completed for Negative Titer | Examiner’s Initials and date |
| #2 Date Booster completed for Negative Titer | Examiner’s Initials and date |

**Varicella – Chickenpox – within 10 years**

| Date Titer Completed | Attach supporting documentation | Examiner’s Initials and date |
| #1 Date Booster completed for Negative Titer | Examiner’s Initials and date |
| #2 Date Booster completed for Negative Titer | Examiner’s Initials and date |

**Hepatitis B Titer - within 10 years**

| Date Titer completed | Results | Examiner’s Initials |

**Hepatitis Series – within 20 years**

| #1 Date Booster completed | Examiner’s Initials and date |
| #2 Date Booster completed | Examiner’s Initials and date |
| #3 Date Booster completed | Examiner’s Initials and date |

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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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 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 (Nursing 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 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: ___________________