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.

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**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 Diptheria**
- Documentation of vaccination or booster within last 10 years.

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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.
**Student Self Report of Medical History**

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

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

<table>
<thead>
<tr>
<th>Home Phone #</th>
<th>Work Phone #</th>
<th>Cell or beeper #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact Name</th>
<th>Relationship</th>
<th>Contact at:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BC Email Address</th>
<th>Program Enrolled:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

**MANTOUX PPD – TUBERCULIN TEST – REQUIRED ANNUALLY**

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

If result of tuberculin test is positive, a chest X-ray is required

<table>
<thead>
<tr>
<th>Chest X-ray Date:</th>
<th>Attach results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Drug Allergies/Medicine Sensitivity/Latex Allergy**

- None
- Penicillin, Ampicillin
- Latex allergy
- Other ________________

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**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.

<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>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integumentary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HEIGHT:** ____________    **WEIGHT:** ____________    **BLOOD PRESSURE:** ____________

**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

<table>
<thead>
<tr>
<th>Test Date:</th>
<th>Attach results of laboratory test</th>
</tr>
</thead>
<tbody>
<tr>
<td>If result of tuberculin test is positive, a chest X-ray is required.</td>
<td></td>
</tr>
<tr>
<td>Chest X-ray Date:</td>
<td>Attach results</td>
</tr>
</tbody>
</table>

### Tetanus/ Diphtheria – required within last 10 years

- [ ] To verify previous vaccination, attach documentation via a medical record or examiner’s statement.
- [ ] 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.*

- [ ] To verify previous vaccination, attach documentation via a medical record or examiner’s statement.
- [ ] Titer Completed - Date:  
  Attach results of laboratory test
  - If Positive Titer  
    No vaccination required, immunity verified
  - If Negative Titer  
    Vaccination Provided  
    Date:
- [ ] 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.*

- [ ] To verify previous vaccination attach documentation via a medical record or examiner’s statement.
- [ ] Titer Completed - Date:  
  Attach results of laboratory test
  - If Positive Titer  
    No vaccination required, immunity verified
  - If Negative Titer  
    Vaccination Provided  
    Date:
- [ ] Vaccination Provided without Titer  
  Date:

### Varicella - Chickenpox

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

- [ ] Titer Completed - Date:  
  Attach results of laboratory test
  - If Positive Titer  
    No vaccination required, immunity verified
  - If Negative Titer  
    Vaccination Provided  
    Date:
- [ ] Vaccination Provided without Titer  
  Date:

### Hepatitis B - Required

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:

- [ ] Verification of previous vaccination  
  Titer Date:  
  Results:
- [ ] 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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