



Broward Community College
Center for Health Science Education
Medical History and Physical Examination Form



The Medical History and Physical Examination form consists of four pages and must be completed by all students entering Center for Health Science Education programs. **Students are responsible for the cost of the physical examination and any required immunizations.** Students may see a doctor (MD or DO), a nurse practitioner (ARNP) or a physician assistant (PA) for the physical examination. In addition to information about the student's general health, this form provides verification that the student is able to carry out the tasks required for his/her chosen career such as standing for long periods, manual dexterity, etc.

Students:

Please review this form carefully. In order for it to be considered complete, you must have:

- Completed the Medical History portion wherein you relate information about your past and current health status
- Completed the Physical Examination portion wherein you have documented that you are medically fit to participate in the program including verification of immunizations
- Reviewed the Technical Performance Standards for the program/profession as detailed on the specific program's web site (refer to www.broward.edu)
- Notarized the contents of the form as "accurate to the best of your knowledge"

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 and notarized may prevent you from progressing to the clinical portion of your program. **Please make copies of the form prior to submitting for your own record.**

Immunization information:

Students must provide valid documentation of immunization **or** have a blood test called a titer which indicates current immunization status **or** receive the indicated vaccinations. Refer to page 3 for specific procedures to follow regarding each of the required titers/immunizations:

- A **Positive Titer Test** indicates that you have either had the disease or have been vaccinated against it. In either case, **you have immunity** to that disease.
- A **Negative Titer Test** indicates that **you do not have immunity** to the disease and that **you will need to be immunized.**

Vaccination for hepatitis is required. In order to confirm immunity, students are advised to have a hepatitis titer after receiving the full series of three vaccinations. Any student who opts not to receive the hepatitis series will need to sign the "Laboratory Tests and Immunizations" page to acknowledge refusal of the vaccinations.

Important: All results of laboratory tests and immunizations should be attached to the Medical History and Physical Examination form.



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Student Self Report of Medical History

Student: Complete this section prior to the physical examination for review by the examiner.

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

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

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 _____ |

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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 a vaccination has been provided. Attach results of laboratory tests as indicated and any documentation 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					
<i>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</i>					
<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				
<input type="checkbox"/>	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; text-align: center; border: none;">If Positive Titer</td> <td style="border: none;">No vaccination required, immunity verified</td> </tr> <tr> <td style="text-align: center; border: none;">If Negative Titer</td> <td style="border: none;">Vaccination Provided Date:</td> </tr> </table>	If Positive Titer	No vaccination required, immunity verified	If Negative Titer	Vaccination Provided Date:
If Positive Titer	No vaccination required, immunity verified				
If Negative Titer	Vaccination Provided Date:				
<input type="checkbox"/>	Vaccination Provided without Titer Date:				

Rubeola - Measles					
<i>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.</i>					
<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				
<input type="checkbox"/>	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; text-align: center; border: none;">If Positive Titer</td> <td style="border: none;">No vaccination required, immunity verified</td> </tr> <tr> <td style="text-align: center; border: none;">If Negative Titer</td> <td style="border: none;">Vaccination Provided Date:</td> </tr> </table>	If Positive Titer	No vaccination required, immunity verified	If Negative Titer	Vaccination Provided Date:
If Positive Titer	No vaccination required, immunity verified				
If Negative Titer	Vaccination Provided Date:				
<input type="checkbox"/>	Vaccination Provided without Titer Date:				

Varicella - Chickenpox					
<i>Student statement of previous exposure IS NOT considered to be proof of immunity.</i>					
<input type="checkbox"/>	Titer Completed - Date: Attach results of laboratory test				
<input type="checkbox"/>	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; text-align: center; border: none;">If Positive Titer</td> <td style="border: none;">No vaccination required, immunity verified</td> </tr> <tr> <td style="text-align: center; border: none;">If Negative Titer</td> <td style="border: none;">Vaccination Provided Date:</td> </tr> </table>	If Positive Titer	No vaccination required, immunity verified	If Negative Titer	Vaccination Provided Date:
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 Provided Injection 1 Date: _____ Injection 2 Date: _____ Injection 3 Date: _____

I certify that the above tests/vaccinations were performed in this office/laboratory or I have reviewed any documentation 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 Community 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 Center for 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 Department Head to determine the accommodation necessary.

Student Signature: _____

Date: _____

Permission to Render Medical Treatment

In case of serious illness or accident, I give Broward Community 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 CHSE 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 statements 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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