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

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 or 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, vaccinations will then be required.

The following sections must be reviewed and signed by the student.

Section 3:
Release of Information

Section 4:
Permission to Render Medical Treatment

Section 5:
Student Statement

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

Last Name	First Name	Student ID #	
Address	City	State	Zip
Home Phone #	Work Phone #	Cell #	
Emergency Contact Name	Relationship	Contact at:	
Email Address		Gender: ____ M _____ F	

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	

Provide information regarding any of the boxes checked above.

____
____
____
____
____

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

____
____
____
____

Drug Allergies/Medicine Sensitivity/Latex Allergy/Food or Environmental Allergy

- ◻ None
- ◻ Latex allergy
- ◻ Penicillin, Ampicillin
- ◻ Other _________________________

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Section 2: 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: __________ PULSE ____________

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:

____

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Section 2 continued: Laboratory Findings and Immunization Verification

Immunization Verification

Attach results of laboratory tests and chest X-rays as indicated.

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**

Tetanus/ Diptheria – required within last 10 years		
☐	To verify previous vaccination, attach documentation via a medical record or examiner's statement.	
☐	Vaccination Provided	Date:

Examiner Instructions: **A titer must be completed t**o verify immunity; **all negative results necessitate a vaccination.** Indicate that vaccinations have been provided in accordance with titer results. **Attach results** of laboratory tests **for the required titers listed below** and chest X-rays **as indicated above**.

Rubella – German Measles		
	Titer Completed - Date:	**Attach results of laboratory test**
☐	If Positive Titer - No vaccination is required as immunity has been verified	
☐	Vaccination provided in accordance with **negative** titer results	Date:

Rubeola - Measles		
	Titer Completed - Date:	**Attach results of laboratory test**
☐	If Positive Titer - No vaccination is required as immunity has been verified	
☐	Vaccination provided in accordance with **negative** titer results	Date:

Varicella - Chickenpox		
	Titer Completed - Date:	**Attach results of laboratory test**
☐	If Positive Titer - No vaccination is required as immunity has been verified	
☐	Vaccination provided in accordance with **negative** titer results	Date:

Hepatitis B - Required				
☐	Titer Completed – Date:	Results:		
☐	Vaccination provided in accordance with titer results	Injection 1 Date:	Injection 2 Date:	Injection 3 Date:

Health Care Examiner's Statement

I have verified that the individual I have examined is the named 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) ____

License # _________________ **Phone** ______________________________________

Signature of Health Care Examiner ______________________________________ **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 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.
I acknowledge that this may affect the program graduation requirements.

Student Signature: Date:

Section 4: 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.

Student Signature: Date:

Section 5: Student Statement

The information provided on the Medical History and Physical Examination form is accurate to the best of my knowledge. I have attached all results of laboratory test and documentation of immunizations as required.

I am aware that the Medical History and Physical Examination form will be reviewed and will be returned to me if there are any incomplete sections or if additional documentation is requested.

I understand that failure to complete the form correctly may jeopardize my participation in the clinical portion of the program.

Student Signature: Date:

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