



## Broward College Medical History and Physical Examination Form

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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.**

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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 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:**

#### **Verification of Compliance with Technical Performance Standards**

### **Section 6:**

#### **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**

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.

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

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

- None
- Penicillin, Ampicillin
- Latex allergy
- 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:

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Is the student now taking any medications? **YES NO**  
 If yes, please list:

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Can student participate in unlimited physical activities in the clinical area? **YES NO**  
 (Technical Performance Standards are provided at the end of this form).  
 If no, please specify limitations:

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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
<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:

**Examiner Instructions: A titer must be completed** to 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	
<input type="checkbox"/>	Titer Completed - Date: Attach results of laboratory test
<input type="checkbox"/>	If Positive Titer - No vaccination is required as immunity has been verified
<input type="checkbox"/>	Vaccination provided in accordance with <b>negative</b> titer results Date:

Rubeola - Measles	
<input type="checkbox"/>	Titer Completed - Date: Attach results of laboratory test
<input type="checkbox"/>	If Positive Titer - No vaccination is required as immunity has been verified
<input type="checkbox"/>	Vaccination provided in accordance with <b>negative</b> titer results Date:

Varicella - Chickenpox	
<input type="checkbox"/>	Titer Completed - Date: Attach results of laboratory test
<input type="checkbox"/>	If Positive Titer - No vaccination is required as immunity has been verified
<input type="checkbox"/>	Vaccination provided in accordance with <b>negative</b> titer results Date:

Hepatitis B - Required			
<input type="checkbox"/>	Titer Completed – Date:	Results:	
<input type="checkbox"/>	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: Verification of Compliance with Technical Performance Standards**

Each Health Science program 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. The standards are found on the last pages of the Medical History form.

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: \_\_\_\_\_

**Section 6: 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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# Technical Performance Standards Massage Therapy Program

## ***Job Description***

Massage therapy is a health care discipline requiring cognitive, sensory, affective and psychomotor performance standards. The Massage Therapist is a skilled professional who administers massage for compensation to patient/clients directly or by physician's prescription. "Massage" means the manipulation of the soft tissues of the human body with the hand, foot, arm, or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation, or thermal therapy; any electrical or mechanical device; or the application to the human body of a chemical or herbal preparation. [Florida State Statutes Chapter 480.033(3)]

Employing knowledge of the patient/client's condition, the Massage Therapist skillfully applies therapeutic and/or relaxing techniques and modalities to alleviate presenting symptoms. Massage therapy has a wide variety of applications, including preventative health care, health maintenance, rehabilitation, stress management, performance optimization and personal growth/development.

## ***Physical Requirements Sensorimotor Skills***

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- Gross and fine motor abilities sufficient to provide safe and effective care including the ability to assist with positioning of patients/clients, standing and walking for extended periods of time, and physical abilities sufficient to move from room to room, to maneuver around massage tables or equipment in patient/clients' rooms or other small areas
- The motor skills of stooping, kneeling, crouching, crawling, reaching, and handling such as required to assist patient/client in therapeutic interventions
- Ability to perform medium work (defined as lifting 60 pound maximum with frequent lifting or carrying of objects weighing up to 30 pounds) such as required to manually assist a patient/client in positioning and transferring
- Fine motor coordination sufficient to use equipment
- Tactile ability sufficient for assessment of data such as pulse, temperature, texture, size, shape, muscle tone and other palpation data
- Auditory ability sufficient to monitor and assess health care needs including but not limited to hearing monitor alarms, emergency signals, auscultatory sounds, and verbal communication as when a patient/client calls for assistance
- Visual ability sufficient for assessing and observing the patient/client and environment including near and far acuity, depth perception, visual fields, and color vision
- Ability to perform therapeutic interventions and safely utilize equipment that requires sensory awareness, ability to perform palpation, possess fine motor coordination to perform equipment calibration and efficient use during treatment

## ***Communication Skills***

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- Possess sufficient communication skills to interact effectively with others verbally, non-verbally and in writing
- Ability to express self verbally in a language that will be understood by a majority of patients/clients
- Ability to explain interventions, provide patient/client education, and assess/relate patient/client response to interventions

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### ***Interpersonal Skills***

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- Possess sufficient interpersonal skills to establish meaningful and effective rapport with patients/clients, families, and colleagues from a variety of different social, emotional, economic, cultural, ethnic, religious and intellectual backgrounds as well as within all age groups
- Respect patient/family confidentiality

### ***Critical Thinking Skills***

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- Ability to identify cause-effect relationship in order to make judgments and set priorities in client/therapist situations
- Recognize physiological changes in patient/client status and act appropriately
- Must be able to function during stressful situations