



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:

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.

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

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

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Penicillin, Ampicillin |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> 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**
 (Technical Performance Standards are provided at the end of this form).
 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
<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 negative 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 negative 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 negative 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 Diagnostic Medical Sonography Program

The Diagnostic Medical Sonographer utilizes high frequency sound waves and other diagnostic techniques for medical diagnosis. The professional level of this health care service requires highly skilled and competent individuals who function as integral members of the health care team. The Diagnostic Sonographer must be able to produce and evaluate ultrasound images and related data that are used by physicians to render a medical diagnosis. The Diagnostic Sonographer must acquire and maintain specialized technical skills and medical knowledge to render quality patient care.

In the professional courses that are required, as well as in the career field of sonography, the student and sonographer must have the ability to:

1. Lift and move patients and accessories
2. Coordinate movement of equipment, such as portable machines and accessories
3. Utilize the skills needed to perform procedures with "universal precautions" when working with all types of patients
4. Give instructions to patients, peers, and healthcare personnel
5. Hear audible cues and warnings of imaging and Doppler equipment and life support devices
6. Utilize the sense of touch in order to provide patient care and position patients for sonographic examinations
7. Exhibit the dexterity to manipulate the transducer in the necessary maneuvers to achieve the optimum examination and to operate the controls of the equipment
8. Evaluate images, distinguishing between black, white, and shades of gray tones, and recognize and evaluate shades of color in images and color flow Doppler
9. Utilize interpersonal skills to professionally and sensitively interact with patients who are experiencing physical or emotional trauma
10. Utilize oral and written communications to assess clinical records, comprehend and employ appropriate medical terminology and interact with the referring and/or attending physician with oral and written impressions regarding sonographic data as permitted by employer policy and procedure
11. Exercise professional judgment and discretion to identify a life-threatening situation and implement emergency care
12. Perform within the **SCOPE OF PRACTICE** (detailed below).
13. Protect the patient's rights and privacy and adhere to the Professional Code of Conduct.

Scope of Practice for the Diagnostic Ultrasound Professional

Preamble:

The purpose of this document is to define the Scope of Practice for Diagnostic Ultrasound Professionals and to specify their roles as members of the health care team, acting in the best interest of the patient. This scope of practice is a "living" document that will evolve as the technology expands.

Definition of the Profession:

The Diagnostic Ultrasound Profession is a multi-specialty field comprised of Diagnostic Medical Sonography (with subspecialties in abdominal, neurologic, obstetrical/gynecologic and ophthalmic ultrasound), Diagnostic Cardiac Sonography (with subspecialties in adult and pediatric echocardiography), Vascular Technology, and other emerging fields. These diverse specialties are distinguished by their use of diagnostic medical ultrasound as a primary technology in their daily work. Certification¹ is considered the standard of practice in ultrasound. Individuals who are not yet certified should reference the Scope as a professional model and strive to become certified.

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Scope of Practice of the Profession:

The Diagnostic Ultrasound Professional is an individual qualified by professional credentialing² and academic and clinical experience to provide diagnostic patient care services using ultrasound and related diagnostic procedures. The scope of practice of the Diagnostic Ultrasound Professional includes those procedures, acts and processes permitted by law, for which the individual has received education and clinical experience, and in which he/she has demonstrated competency.

Diagnostic Ultrasound Professionals:

- Perform patient assessments
- Acquire and analyze data obtained using ultrasound and related diagnostic technologies
- Provide a summary of findings to the physician to aid in patient diagnosis and management
- Use independent judgment and systematic problem solving methods to produce high quality diagnostic information and optimize patient care.

¹ An example of credentials: RDMS (registered diagnostic medical sonographer), RDCS (registered diagnostic cardiac sonographer), RVT (registered vascular technologist); awarded by the American Registry of Diagnostic Medical Sonographers,[®] a certifying body with NCCA Category "A" membership.

² Credentials should be awarded by an agency certified by the National Commission for Certifying Agencies (NCCA).

Endorsed by:

- Society of Diagnostic Medical Sonography
- American Institute of Ultrasound Medicine
- American Society of Echocardiography*
- Canadian Society of Diagnostic Medical Sonographers
- Society for Vascular Ultrasound

* Qualified endorsement