ORANGE COAST COLLEGE

School of Allied Health Professions **Program ________________**

MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM

Student Name__________________________________ **Student ID#**________________

Directions to Student: *Fill out Part I entirely before seeing the physician. Have the physician complete Part II through Part VII at the time of your physical examination. Bring the completed form back and submit to your program director.*

I. HEALTH HISTORY *(This part must be completed by the student before seeing the physician.)*

Last Name ____________________ First Name ________________________ Birth date __________

Address ________________________________ City/State/Zip ____________________________

Email ______________________________ Telephone ______________________________

PERSON TO NOTIFY IN CASE OF EMERGENCY

Last Name _____________________ First Name ________________________

Address ________________________________ City ________________ State _____ Zip __________

Home Phone ____________________________ Cell Phone ___________________________________

LOCAL PHYSICIAN PREFERENCE

Name ____ Office Phone _____________________

PAST MEDICAL HISTORY AND ILLNESSES - Indicate any of the following that apply:

- ❑ Rheumatic Fever
- ❑ Heart Murmurs
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Tuberculosis
- ❑ Asthma/Hay Fever
- ❑ Difficulty in Breathing
- ❑ Pneumonia
- ❑ Diabetes
- ❑ Stomach/Intestine Problems
- ❑ Hernia
- ❑ Thyroid Problems
- ❑ Kidney Disease
- ❑ Fainting
- ❑ Recurring Headaches
- ❑ Mental Illness
- ❑ Epilepsy/Convulsions
- ❑ Meningitis
- ❑ Amputations
- ❑ Athletic Injuries
- ❑ Back Problems
- ❑ Anemia
- ❑ Major Illnesses: ______________________
  ____
- ❑ Surgeries: __________________________
  ____
  ____

If any items are checked above, please explain: ____
____
____

Student Name___________________________________ **Student ID#**_________________

Revised 02/19/2016

❑Yes ❑No Do you have any physical impairment such as loss of hearing, vision, or paralysis?

If yes, please explain: ____

❑Yes ❑No Do you have any allergies? If yes, please explain: ________________________________

❑Yes ❑No Do you take medication regularly?

If yes, please explain: ____

General Family Health: Parents ____

Siblings ____

Grandparents ____

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION GIVEN ABOVE IS COMPLETE AND CORRECT.

Student Signature____ Date _______________

I AUTHORIZE THE RELEASE OF ALL ALLIED HEALTH PHYSICAL EXAM RESULTS INCLUDING LAB RESULTS, TUBERCULIN TESTS, AND IMMUNIZATIONS TO THE ORANGE COAST COLLEGE ALLIED HEALTH PROGRAM.

____

Student Signature Date

II. PHYSICAL EXAMINATION *(To be completed by the physician.)*

Date ____________________

Height _________’________” Weight ____________ B/P __________________ Pulse ___________

	Normal	Abnormal	Explain:
General Appearance	❑	❑	
Head	❑	❑	
Hearing	❑	❑	
ENT	❑	❑	
Vision	❑	❑	
Eyes	❑	❑	
Neck	❑	❑	
Chest	❑	❑	
Heart	❑	❑	
Abdomen	❑	❑	
Extremities	❑	❑	
Skin	❑	❑	
Lymph Nodes	❑	❑	
Reflexes	❑	❑	
Thyroid	❑	❑	

Abnormal findings should be described, with a separate comment regarding whether the condition interferes with clinical performance related to the program indicated on page 1. _____________________

____

____

Student Name___________________________________ **Student ID#**__________________

Revised 02/19/2016

Do not obtain any immunizations until seen by your medical provider.

III. REQUIRED IMMUNIZATIONS and/or IMMUNITY

(Attach copy of all lab results and all immunization records when applicable)

A. MMR: One or both of the following must be met:

- ❑ Documented proof of Two Immunizations**: (DA, PSG and SLPA only needs proof of immunization)**

  Dates 1st __________ 2nd __________ (4 wks. after 1st dose)

  AND/OR

- ❑ Titer documenting immunity **(Mandatory for CVT, DMS, EMS, MA, NDT, RC, and RT Programs)**

  Measles Titer Results _________________________ Date ___________

  Mumps Titer Results _________________________ Date ___________

  Rubella Titer Results _________________________ Date ___________

  Per CDC guidelines, 2 doses of MMR are required 4 weeks apart unless medically contraindicated. If there is documentation of MMR immunization but the titer is negative, boost with 1 MMR then re-titer in 4-6 weeks. If the second titer is negative, please provide written documentation stating the student is a non-responder NOTE: If planning to receive MMR immunization, have PPD completed first.

B. VARICELLA (If varicella and/or MMR vaccines and PPD testing are not administered at the same visit, they should be separated by at least 28 days.)

- ❑ Varicella Immunization Titer Results __________________ Date:___________

  If titer is negative and there is no proof of vaccine, 2 doses of varicella are required 28 days apart.
  SLPA only needs vaccine; all other programs need vaccine IF the Titer is negative.

- ❑ Documented proof of Two Immunizations: Dates 1st __________ 2nd – _________________________ (28 days)

C. INFLUENZA:

(Annually – fall semester) Date______________

D. TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS (Tdap):

- ❑ Documented proof of **Tdap** Vaccination AFTER age 10: Date ______________________

IV. RECOMMENDED IMMUNIZATIONS: All Progarms

A: HEPATITIS B VACCINE

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(Pre-Clinical clearance MANDATORY in CVT, DA, DIET. DMS, EMS, MA, NDT, PSG, RT, RC, SLPA

2 Step Process: The attending physician/provider may choose this option if available.

Dose #1____________________ Dose #2: _______________________

Proof of Immunization Titer: Date: ___________________________________

Standard Process: Pre-Clinical clearance Mandatory CVT, DA, DIET, DMS, EMS, MA, NDT, PSG, RT, RC, SLPA

Hepatitis B Titer: Results: ________________________________ Date: ________________

Per CDC guidelines, if the HepB titer is negative, a "challenge" dose of HepB vaccine is required followed by a HepB titer 1-2 months later. If the second titer is negative, please provide written documentation stating the student is a non-responder.

Hepatitis B Vaccine: (**DA only needs proof of immunization not a titer**) Dose in intervals 0,1,6 months
1st Vaccine Date: _____________ 2nd vaccine Date: _____________ 3rd Vaccine Date: ____________ Proof of Immunization Titer: Date: ______________________

Student Name___________________________________ **Student ID#**_________________

Revised 04/12/2019

V. REQUIRED LABORATORY TESTS - TUBERCULOSIS

(Attach a copy of the TB test and/or radiologist report if a chest x-ray was performed)

❑ Two Step PPD Tuberculosis Clearance (Annual) [1] **(SLPA only needs 1 TB test)**

1st dose: Results ____________________ Date ______________ (If positive no further skin testing done[2]) (If negative do 2nd test 1-3 weeks later)

2nd dose: Results ________________________ Date:__________(If positive[3])

OR

QuantiFERON TB Gold assay (Blood Test) **N-**

Negative **Positive** **Indeterminable**

Date:___________

❑ Chest X-ray (within last 12 months): Results ____________________________ Date ___________________

[1] If documented previous positive PPD, no skin testing is performed and follow-up including TB symptom screening (to be completed yearly), and blood test or chest X-ray is required. The two-step PPD only needs to be done once if the next PPD is done within the year. If the PPD is done after the year, then a two-step needs to be re-done.

[2] Person would require follow-up including chest X-ray and evaluation for appropriate medication and/or follow-up therapy.

[3] Person is classified as "previously infected" and has documented treatment that meets the current United States tuberculosis treatment protocol

VI. PRACTITIONER/PROVIDER DISCRETIONARY TESTS

(Attach copy of lab results)

❑ CBC Results _____________ Date _____________

❑ Urinalysis Results _____________ Date _____________

❑ Other Results _____________ Date ____________

VII. MEDICAL CLEARANCE TO PARTICIPATE

FOR PHYSICAL AND EMOTIONAL STANDARDS SEE APPENDIX A ON PAGE 5

Please state your professional medical opinion: Is there any emotional, mental, or physical condition that may interfere with this student's ability to perform in the clinical setting?

❑Yes ❑No

Remarks:

____

____

Provider Name: ______________________________ **Signature:** __________________________________

Address: _____________________________________ **City:** ______________ **State:** _____ **Zip:** _____

Office Phone: ____________________ **OCC Health Center:** ___YES ____NO _____

Date: ___________________

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APPENDIX A
Orange Coast College School of Allied Health Professions
Medical Exam Information Sheet

In the best interest of our students, please be aware that certain physical, emotional and learning abilities are necessary in order to protect the individual student's well-being and provide for the safety of each patient/client placed in their care. The following are basic physical and emotional abilities required of the student for success in their Allied Health Program:

Standing/Walking - Much of the workday is spent standing. Approximate walking distance per shift: 3-5 miles while providing care, obtaining supplies and lab specimens, monitoring and charting patient response, and managing/coordinating patient care.

Lifting - Some of the work day is spent lifting from floor to knee, knee to waist, and waist to shoulder levels while handling supplies (at least 30 times per shift). These supplies include trays (5 to 10 pounds) and equipment (5 to 35 pounds). The Allied Health Student must also assist with positioning patients or moving patients (average patient weight is 150 - 200 pounds).

Carrying - Some of the workday is spent carrying charts, trays and supplies (5 to 10 pounds).

Pushing/Pulling - A large part of the workday is spent pushing/pulling while moving or adjusting equipment such as beds, wheelchairs, furniture, intravenous pumps, diagnostic/treatment equipment, and emergency carts.

Balancing and Climbing - Part of the workday is spent climbing stairs. The Allied Health Student must always balance self and use good body mechanics while providing physical support for patients/clients.

Stooping/Kneeling - Some of the workday is spent stooping/kneeling while retrieving and stocking supplies and medications, assessing equipment attached to patients/clients and using lower shelves of carts.

General Extremity Motion (upper and lower extremities) - It is evident from the previous statements that extremity movement is critical. Movement of the shoulder, elbow, wrist, hand, fingers and thumb is required throughout the workday. Movement of the hip, knee, ankle, foot and toes are also required throughout the workday. It is necessary for the student to be able to turn, flex and extend their neck.

Hearing - A majority of the workday requires an ability to hear and correctly interpret what is heard. This not only includes taking verbal or telephone orders and communicating with patients, visitors and other members of the health care team; but also involves the physical assessment of cardiovascular, pulmonary and gastrointestinal sounds and the analysis of patient monitor alarms.

Vision – Correctable with glasses able to read standard fonts and medication inserts.

Emotional- A student must be emotionally stable under normal and stressful circumstances encountered in the health care setting.

To participate in Allied Health clinical training, the selected applicant needs to be free from any physical, behavioral, emotional or mental condition that would adversely affect their behavior so as to create an undue risk or harm to themselves, other students, instructors, patients in the clinical setting, or other persons.

If an applicant disputes a determination that they are not free from such a physical, behavioral, emotional or mental condition, the Program Director and the Dean of Allied Health shall confer with the Director of the Student Health Center. The applicant may be required, at their own expense, to be examined by either a licensed physician and/or surgeon, or by a licensed clinical psychologist. If the health practitioner deems the applicant safe to participate in the Allied Health Program, the information is shared with the Allied Health Clinical Admission Committee (AHCAC) and the Committee determines if the applicant is granted a clinical placement.

The above conditions also apply to students who are currently enrolled in Allied Health Programs. Maintenance of good health (physical, behavioral and emotional) is essential for continuation in the program.