Richmond Community College

Allied Health

Student Health Form

Instructions for Completion of the Student Health Form

The information provided in this health form by the student and the health care provider is confidential and protected by the Health Insurance Portability and Accountability Act Privacy Rule.

1. The student must complete and sign the Personal and Family History prior to the physical exam.

2. The student should complete the immunization requirements and must provide the school with documentation of any immunizations, titers, or screening tests done prior to the current physical exam. If new immunizations, blood tests, or screening tests are done during the physical exam visit, the health care provider must document, initial those, and sign the immunization summary.

3. Students who are providing titers showing immunity in lieu of a vaccination record must submit the laboratory result documenting the titer.

4. Students claiming a disease history in lieu of any vaccinations and titers must provide the record from the medical facility where the disease was originally diagnosed and treated.

5. The health care provider must complete and sign the physical exam form.

Instructions regarding immunizations and health screening tests

To protect both you and your patients, our clinical agencies require the following immunizations and health screening tests. To attend clinical rotations, you must provide all the required information unless you have a documented medical contraindication. Use the following checklist to confirm that you have provided all required information regarding immunizations and health screening tests.

_____ **Measles, mumps, rubella (MMR)**

Unless you were born before 1957, you must provide the following:

• Two MMR vaccinations after your first birthday OR Titers showing immunity to each of the three disorders

_____ **Varicella**

• Two varicella vaccines OR Titer showing immunity (Surg Tech will need a Positive titer for clinical requirements).

_____**Tetanus/diphtheria (TD) or adult tetanus/diphtheria/pertussis (Tdap)**

• You must have a documented tetanus booster within the past 10 years.

_____ **Tuberculosis screening**

Screening with a TST within 12 months of starting program (Note: Current and annual TB test required). Documentation of results must be in mm of induration.

OR

· TB Blood Test (i.e. IGRA) within 12 months of starting program (must provide lab report)

OR

· Documentation by medical provider of a chest x-ray is required for a past + PPD or blood test. If current +PPD or blood test, additional evaluation for TB disease will be required as deemed necessary from a healthcare provider.

Students must report any community or clinical exposure to TB immediately to the school, and complete annual TB education and a TB Risk Assessment and Symptom Screen.

_____ **Hepatitis B**

Energix-B or Recombivax-B three (3) doses required (0, 1, and 6 months)

OR

Heplisav-B two (2) doses required (4 weeks apart)

OR

Documentation* of a positive Hepatitis B titer

*must provide lab report that indicates reference range

OR - Declination or waiver signed

Note: Declination or waiver must be on file at the school and/or be approved by the clinical facility or agency. Declination of vaccine is subject to approval from clinical agency.

Influenza

• Influenza immunization is not part of your admission requirements, but you will be required to receive the vaccine annually during the flu season unless you have a documented medical contraindication or religious objection. Declination of influenza may result in inability to participate and complete clinical requirements. You will be informed of the appropriate time to receive this vaccination.

COVID-19

• The COVID-19 vaccination is not required by hospitals surrounding RCC for participation in clinical requirements. The hospital will have the final decision if there are any exemptions or changes to this requirement. If the exemption is denied the student will not be able to participate in clinical activities and therefore unable to meet all program requirements.

Health and immunization requirements are based upon contractual agreements between the Richmond Community College Allied Health Department and clinical agencies that provide clinical learning environments for students. Students must follow all health/immunization requirements to be eligible to participate in clinical opportunities at each facility's discretion. If a student does not meet and maintain health/immunization requirements for a specific agency, they are not eligible to participate in clinical in that facility. If the Department Chair determines that a student cannot satisfactorily meet clinical requirements of the program, the student will not be allowed to progress in the program and will be dismissed from the program.

Personal and Family Health History

Pages 4-6 are to be completed by students prior to the physical exam.

Last Name: _____ **First Name:_____**

Middle initial: _____ **Date of Birth: _____**

Social Security # (last 4 digits) _____ **Gender Preference _____**

Address: _____

Preferred Phone: _____

Emergency Contact and Phone Number: _____

.....

Please list all allergies. (Medications, environment, food, latex, etc.) If so, what is your reaction?

_____

_____

_____

_____

_____

Check any illness or medical conditions that you have had:

___ high blood pressure

___ rheumatic fever

___ heart disease

___ asthma

___ other lung disorder

___cancer

___ malaria

___ thyroid disorder

___ diabetes

___ allergies

___ arthritis

___ frequent headaches

___ severe head injury

___ autoimmune disorder

___ disabling depression

___ anxiety

___ gastrointestinal disorder

___ hepatitis

___ hernia

___ fatigue

___ **anemia**

___ **recurrent back pain**

___ **kidney infection**

___ **sexually transmitted infection**

___ **vision or eye disorder**

___ **neck or back injury**

___ **hearing loss**

___ **blood transfusion**

Provide details about any items checked. Attach an additional sheet if necessary.

_____
_____
_____
_____

Do you smoke? ____ How many cigarettes/day? ____

Drink alcohol? _____ How many drinks/wk? ____

List all medications you take regularly.

_____
_____
_____
_____
_____

Has any person related to you by blood had any illness or condition below? If so, check the condition and state the relationship of the family member to you.

___ **high blood pressure** _____

___ **stroke** _____

___ **heart disease** _____

___ **blood disorder** _____

___ **high cholesterol** _____

___ **diabetes** _____

___ **glaucoma** _____

___ **cancer** _____

___ **substance abuse** _____

___ **psychiatric illness** _____

Do you have any conditions that limit your physical activity?

_____

_____

Have you ever been hospitalized? Specify when and why.

_____

_____

Have you received treatment for a psychiatric, emotional, or behavioral disorder?

_____

_____

Do you have any vision problems not corrected with glasses or contact lenses or any hearing impairment?

_____

Have you seen a physician in the past six months for anything other than routine well visits?

_____

_____

Have you had any serious injuries or illnesses not already noted?

_____

_____

Statement: I have personally supplied the above information and attest that it is accurate and true to the best of my knowledge.

Signature of student _____ Date _____

Printed name of student_____

Immunization Record **Name** _____

The student should complete the Immunization Record prior to the exam and provide documentation of any prior immunizations, titers, or screening tests to support the previous immunizations. If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

Required Immunizations

	Date	Date	Date	Date
DTP or Td (initial series)	___/___/___	___/___/___	___/___/___	___/___/___
Td or Tdap Booster (most recent)	___/___/___			
MMR (a after 1st birthday) or titer	___/___/___	___/___/___		
Varicella (2) or titer	___/___/___	___/___/___		
Hepatitis B (initial series)	___/___/___	___/___/___	___/___/___	
Hepatitis B Booster (if non-immune) titer required	___/___/___			
Hepatitis B (optional to complete series) titer required	___/___/___	___/___/___		
Influenza (seasonal)	___/___/___	___/___/___	___/___/___	___/___/___

Titers (where indicated)

	Date	Result
Rubeola (measles)	___/___/___	
Mumps	___/___/___	
Rubella	___/___/___	
Varicella	___/___/___	
Hepatitis B titer 1(after original series)*	___/___/___	**mlU/mL***
Hepatitis B titer 2(after single booster)*	___/___/___	**mlU/mL***
Hepatitis B titer 3(after 2nd series of 3) OPTIONAL*	___/___/___	**mlU/mL***

*A quantitative hepatitis B titer result is required.

Tuberculosis screening (most recent) Either PPD or TB blood testing is acceptable for allied health students.

	Date	Date (TST)	Interpretation
PPD Placed	___/___/___	___/___/___	**N/A**
PPD Read (pos or neg) Or	___/___/___	___/___/___	
QuantiFERON Gold or T-Spot (pos, neg, or indeterminate)	___/___/___		

Or

	Date	Result
Chest X-ray (pos or neg)	___/___/___	
Record of TB screening (attach form and indicate low risk or high risk)	___/___/___	

If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

_____ **Date:** _____

Signature of Healthcare Provider

_____

Printed Name of Health Care Provider

Physical Examination **Name** _____

Height _____ **Weight** _____ **TPR** _____/_____/_____
BP _____/_____

	Normal	Abnormal	Descriptions or Comments
Head, ears, nose, throat			
Eyes			
Respiratory system			
Cardiovascular system			
Gastrointestinal system			
Abdomen			
Genitourinary system			
Musculoskeletal system			
Endocrine system			
Neurological system			
Skin			
Mental health status			

Is the student under treatment for any medical condition? If yes, provide brief details of the disorder and treatment.

_____
_____
_____

Are there currently any limits on the student's physical activity? How long will these limits apply?

_____
_____
_____
_____

Examiner's Statement: Based on my assessment of this student's physical and mental health, at this time s/he appears to be able to participate in the activities of a health profession in a clinical setting. Yes_____ No _____(please explain)

Comments:

_____
_____
_____
_____
_____
_____
_____
_____

_____ **Date:** _____
Signature of Healthcare Provider

_____
Printed Name of Health Care Provider

Office Phone Number: _____

_____
Office Address City State Zip Code

The physical examination for Richmond Community College Allied Health Programs includes an assessment of the applicant's physical and emotional health prior to participation in a clinical setting. These criteria should be included in the assessment:

Meets Criteria	Does Not Meet Criteria	Skills
		Communications Skills: Students shall possess communication abilities sufficient for verbal and nonverbal interaction with others. Example: Students shall be able to explain treatment procedures and provide patient teaching to clients and families, document client response, and report to others the client's response to care.
		Mobility: Students shall possess physical abilities sufficient to move from room to room and maneuver in small spaces and stand and walk for extensive periods of time. Example: Students will be able to move around in client's room, move from room to room, move in small work areas, and administer CPR.
		Motor Skills: Students shall possess gross and fine motor skills sufficient to provide safe and effective patient care.
		Hearing Skills: Students shall possess auditory ability sufficient to monitor health needs and collect data.
		Visual Skills: Students shall possess visual ability sufficient for observation and data collection.
		Tactile Skills: Students shall possess tactile ability sufficient for data collection.
		Weight-bearing: Students shall possess the ability to lift and manipulate/ move 40-50 pounds

Explanation of criteria NOT met and projected time frame, if applicable:

_____

_____

_____

_____

_____

_____ _____

Signature of Healthcare Provider **Date**

Richmond Community College

Allied Health Department

HEPATITIS B VACCINE DECLINATION (WAIVER)

Student Name (print): _____

I am declining the Hepatitis B vaccination currently. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at high risk of acquiring Hepatitis B Virus (HBV) infection. I have read the Hepatitis B Vaccine Information Statement (VIS) https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf. I understand the protection the vaccine could offer and have been given the opportunity to be vaccinated at my expense. However, I am declining Hepatitis B vaccination currently. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I want to be vaccinated with Hepatitis B vaccine, I will arrange to obtain the vaccine from my health care provider and notify the Nursing Department Chair and supply promptly the appropriate documentation to include in my health record.

For the following reason, I decline vaccination currently:

☐ **Personal reasons.**

☐ **I have previously received the complete series of three Hepatitis B vaccination.**

☐ **Antibody testing has revealed that I am immune to Hepatitis B.**

☐ **Medical reasons, the Hepatitis B vaccine is contraindicated. Attach medical documentation concerning the medical contraindication to the Hepatitis B vaccine.**

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_____ _____

Student Signature **Date**