Name

Health Occupation Programs
History and Physical
Examination Form

(To Be Completed by the Student)

Program: (Check One)

- ○ Associate Degree Nursing
- ○ Massage Therapist
- ○ Nursing Assistant
- ○ Physical Therapist Assistant
- ○ Surgical Technology
- ○ Dental Hygiene
- ○ Medical Assistant
- ○ Phlebotomy
- ○ Radiologic Technology
- ○ Medical Lab Tech
- ○ Practical Nursing
- ○ Respiratory Therapy

Student Name: _____ _____ _____ _____
Last First Middle Maiden

Address: _____ _____ _____ _____
Street City State Zip Code

Phone: _____ _____ _____ **DOB:** _____/_____/_____
Home Work Cell MM DD YYYY

Emergency Contact: _____ _____ _____
Name Relationship Phone

_____ _____ _____ _____
Street City State Zip Code

Check the appropriate answer to each of the following:

Yes	No		Yes	No	
_____	_____	Rheumatic Fever	_____	_____	Heart Disease
_____	_____	Emotional Disorder/Disability	_____	_____	Back Injury
_____	_____	Color Blind	_____	_____	Hemophilia
_____	_____	Diabetes	_____	_____	Asthma
_____	_____	Allergies to Latex**	_____	_____	Epilepsy/Seizures**

If Yes, Please See Your Healthcare Provider

Please specify all allergies: _____

Please read carefully and sign:

I understand that there are conditions for which accommodations may be appropriate under the Americans with Disabilities Act and that the Health Occupation Programs will make all reasonable accommodations required by law for otherwise qualified individuals. To receive accommodations, I must contact the Office for Students with Disabilities.

I understand that any health care costs incurred during the period of time I am a student in the Health Occupation Programs will be my responsibility.

I hereby grant Lake Superior College permission to share information contained in the Health Examination and Immunity Requirement forms with those clinical institutions with whom I affiliate in my student role, should the clinical institution request or require it.

I understand that failure to sign this form or to provide the information requested in the Health Examination and Immunity Requirement forms could mean that a clinical site may refuse me placement at their facility. The Health Occupational Programs do not guarantee an alternative facility placement. I also understand that if no alternative facility placement is available, I may be terminated from the Health Occupational Programs.

_____ _____/_____/_____
Student's Signature Month Day Year

Communicable Disease Immunity Screening Form for Healthcare Students

Name of Healthcare Student: _____Date of Birth:_____

Please have the PROVIDER THAT MAINTAINS RECORDS OF YOUR IMMUNIZATIONS AND IMMUNITY HISTORY COMPLETE THIS FORM. An *official* copy of your immunization/immunity records (Doctor's Office, Schools, and Military) may be attached to this form. Persons who are unable to provide evidence of immunity, will be required to be tested and/or immunized, as indicated.

Name of facility/provider providing information: _____ Phone:_____

Signature of provider providing information:_____Date:_____

Required Immunity		
Disease	The above named person has documentation of (√ all that apply)	Date(s)
Measles	☐ A positive antibody test for measles **OR** ☐ Two (2) doses of measles or a measles/mumps/rubella (MMR) vaccine received after 1st birthday	
Mumps	☐ A positive antibody test for mumps **OR** ☐ Two (2) doses of mumps or a measles/mumps/rubella (MMR) vaccine received after 1st birthday	
Rubella	☐ A positive antibody test for rubella **OR** ☐ One (1) dose of rubella or a measles/mumps/rubella (MMR) vaccine received after 1st birthday	
Pertussis	□ One dose of tetanus, diphtheria, pertussis (TDAP) vaccine *NOTE: Tdap **is not** the same as the other vaccines containing some or even all of the vaccine components (D-T-A-P) such as DTap, TD, or DT. Within the last 10 years*	
Varicella (Chickenpox)	□ Physician diagnosed varicella or herpes zoster **OR** □ A positive antibody test for chickenpox (varicella zoster) **OR** □ Two (2) doses of Varivax (Chickenpox Vaccine)	
Tuberculosis (TB)	**Evidence of negative tuberculosis screening within the past 12 months** (√ method)	**Date**
	☐ A negative Tuberculin Skin Test (TST) performed within the past 12 months *NOTE: TST is another name for PPD or Mantoux test* If this is the first test for this person, or if it has been more than 12 months since the person had a negative TST, a two- step test is required. If the first TST is negative, the second TST must be administered 1-3 weeks after the first test is read.	Date: _____ induration: _____mm Date: _____ induration: _____mm
	☐ ***OR*** a negative blood test for TB within the past 12 months	
	OR **IF history of positive TST OR blood test for TB you will need the following:** ☐ Medical clearance by provider including a chest X-ray within the past 12 months. **If this box is checked, attach a copy of the most recent chest x-ray and medical evaluation / treatment.**	

Hepatitis B Report 3 doses ***OR*** Titre date & results ***OR*** □ Signed Waiver	**Dose 1 Date** _____/_____/_____ **MM DD YYYY**	**Dose 2 Date** _____/_____/_____ **MM DD YYYY**	**Dose 3 Date** _____/_____/_____ **MM DD YYYY**	**Titre Date** _____/_____/_____ **MM DD YYYY** **Results:**

RECOMMENDED (Not Mandatory)		**Date**
Influenza – annual *October 1 thru March 31*	☐ 1 dose of influenza vaccine for current influenza season	
Meningococcal (*Recommended for Med Lab Tech Students Only)*	□ MCV4 vaccination	

If student is pregnant and vaccinations are needed to meet immunity requirements, they **MUST** be received after delivery. If pregnant, please indicate:

Due Date:_____ Form Revision Date:_____

(To be Completed by the Physician or their Designee)

EXAMINER: the individual presenting this form is admitted to the Lake Superior College Health Occupation Programs. You are asked to make **careful examination** of the individual and their history to determine if the individual is in **sufficiently good health** to undertake a program in health occupations.

Student Name: _____ _____ _____ _____
Last First Middle Maiden

Blood pressure: _____/_____

Vision: Is the student's visual ability sufficient for observation, assessment, and performance of safe patient care such as reading of mercury and digital thermometers, sphygmomanometers, fine print on drug vials and literature, demarcations on insulin, tuberculin and other syringes, computer terminals and medical records, etc.

Check appropriate response:

_____ Yes, without correction _____ Yes, with correction _____ No

Comment(s):

Hearing: Is the student's auditory ability sufficient to hear normal conversation and/or assess health needs such as telephone conversations, auscultation of blood pressures, apical pulse, lung and bowel sounds using a stethoscope, hear and locate source of equipment warning signals when in or outside patient rooms, etc.

Check appropriate response:

_____ Yes, without use of hearing aid(s) or adaptive equipment _____ Yes, with hearing aide(s) [_____ left / _____ right]
_____ Yes, with adaptive equipment (e.g., amplified stethoscope) _____ No

Comment(s):

Ambulation: Is the student's ambulatory capability sufficient to maintain a center of gravity when met with an opposing force as in lifting, supporting, and/or transferring a client. Can the student tolerate long periods of sitting and/or standing?

Check appropriate response:

_____ Yes _____ No

Comment(s):

Weight Bearing/Lifting: Is the student sufficiently able to bear or lift weight to accomplish common health occupation functions such as moving and lifting patients in bed, wheelchair or cart, assist with transfer and walking of patients who may require substantial support and moving of heavy equipment (e.g., hospital beds, meal carts), any of which may involve moving or supporting equal or greater weight than the student themselves (25 pounds frequently, 50 pounds less often).

Check appropriate response:

_____ Yes _____ No

If the student is unable to perform the listed weight bearing/lifting activities, please state below:

1. Why (nature of the problem)
2. If any restriction(s) in bearing and/or lifting of weight and/or bending exist and state the specific restriction(s)
3. If the restriction(s) is/are permanent or temporary (give date of anticipated removal of restriction(s), if temporary)

Comment(s):

Immune Status: Health Occupation students are assigned in clinical areas where exposure to infection and communicable disease is common. Is the student's immune response or status sufficient to allow assignment in all clinical areas and to all patients (assuming use of protective measures ordered by the facility)?

Check appropriate response: _____Yes _____No

If the student's immune response or status is not sufficient to allow assignment in all clinical areas and to all patients (assuming use of protective measures ordered by the facility), please state below:

1. The condition(s) and/or treatment which make the student vulnerable to infection
2. If there is a:
   a. permanent problem
   b. temporary problem. If so, state date when student may be exposed to pathogens commonly found in a hospital setting.
   c. episodic problem. If so, describe the student's current status.

Comment(s):

Lake Superior College
Certification of Annual Physical Examination

This is to certify that _____ (Student Name) had a physical examination

on _____ (Date of Exam)

Please check one of the following:

☐ I certify that this student is in apparent good health, has no condition that would endanger the health and well-being of other students or patients, and is physically / mentally able to perform the customary duties of a health occupation student/employee at Lake Superior College.

☐ I certify that this student may not be able to perform physically / mentally the customary duties of a health occupation student / employee at Lake Superior College based on the following limitations established in the criteria listed on Lake Superior College's Health Occupation Program History and Physical Examination Form. (Please Explain):

_____

_____

_____

_____
Healthcare Provider's Signature Date

_____
Healthcare Provider's Printed Name / Title Phone

_____
City, State, Zip Code

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