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 _____

Email _____ Telephone _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Last Name _____ First Name _____ Birth date _____

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#**_____

❑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: Mother _____

Father _____

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	❑	❑	
ENT	❑	❑	
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._____

_____

_____

Student Name_____ **Student ID#**_____

III. REQUIRED VACCINATIONS and/or IMMUNITY

A. MMR: One of the following must be met:
(Attach copy of lab results or immunization record)

❑ Documented proof of Two Vaccinations: Dates 1st _____ 2nd _____ (4 wks. after 1st dose)

OR

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

Measles Titer Results _____ Date _____

Mumps Titer Results _____ Date _____

Rubella Titer Results _____ Date _____

If titer results are negative, 2 doses of MMR are recommended 4 weeks apart unless medically contraindicated OR if they know if they have had previous MMR, boost with 1 MMR dose then re-titer in 4-6 weeks (as per CDC guidelines) **NOTE:** If planning to receive MMR immunization, have PPD completed first.

B. VARICELLA: *(Attach copy of lab results or immunization record)*

❑ Varicella Titer Results _____ Date _____

If the titer is negative and there is no proof of vaccine, 2 doses of varicella are required 28 days apart.

C. INFLUENZA: *(Attach copy of immunization record)*

(Annual – Before beginning clinical) Date_____

D. TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS (Tdap):
(Attach copy of immunization record)

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

IV. RECOMMENDED IMMUNIZATIONS: *(Attach copy of lab results and/or immunization record)*

A. HEPATITIS B VACCINE:
(Pre-Clinical clearance MANDATORY in DA, EMS, MA, RT and RC Programs)

❑ Hepatitis B Vaccine

Date of 1st Vaccine _____ Date of 2nd Vaccine _____ Date of 3rd Vaccine _____

OR

❑ Hepatitis B Titer Results_____ Date _____

OR

❑ Per CDC guidelines, give a booster dose and check serology 4-6 weeks post-vaccination. If there is no positive titer, readminister the remaining 2 doses counting the booster as dose #1.

Results_____ Date _____

B. TETANUS BOOSTER:

❑ Tetanus Booster (Td) - if Tdap is more than 10 years old Date _____

(Form is continued on Page 4)

Student Name_____ **Student ID#**_____

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]

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

❑ 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 a 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 cared for accordingly.

VI. PRACTITIONER 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: _____

_____

_____

_____

_____

_____

Physician's Signature _____ **Date** _____

Address _____ City _____ State _____ Zip _____

Office Phone _____

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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.

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.