Allied Health & Public Service
Student Medical Form
for
North Carolina Community College
System Institutions

Student Medical Form, Physical Examination sheet, and immunizations must be submitted to your program department by _____**.**

The Physical Examination form on page 6 must be signed by a physician, PA, FNP or have an agency stamp (ie. Health Department).

The flu vaccine must be taken after September 1st and before October 31st. Official record of flu vaccine is required.

_____ _____
Name of Student Name of Program

_____ _____
Student ID# Name of Faculty Advisor

Asheville-Buncombe Technical Community College
Allied Health & Public Service
Rhododendron Building
340 Victoria Road
Asheville, NC 28801

Revised 3/05/13

STUDENT MEDICAL FORM CHECKLIST

Acceptable completed forms MUST be in the student file.

1. **Report of Medical History** and **Family & Personal Health History (pages 3 and 4)**
   - Must be completed by the student and signed.

2. **Physical Examination (page 6) must be completed -** Statement of student's **physical and mental/emotional** health **must** be completed, dated, and signed by physician, PA. FNP or have an agency stamp.

3. **Allied Health students must provide written documentation of receiving the following vaccinations/tests (page 5):**

IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Acceptable Records of Your Immunizations May be Obtained from Any of the Following (Be certain that your name, date of birth, and ID Number appear on each sheet. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. **Keep a copy for your records.**)

High School Records - These may contain some, but not all of your immunization information.

- Personal Shot Records-Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department.
- Military Records or WHO (World Health Organization Documents).
- Previous College or University-Your immunization records do not transfer automatically. You must request a copy.
- Health care facilities where you may be employed

PPD: Tuberculin Skin Test: Must be repeated annually. If positive, chest x-ray. Treatment must be documented if necessary. Annual waiver from the local health department or health care facility must be completed annually.

Tdap (Tetanus-Diptheria-Pertussis) A Td booster must be repeated every 10 years. Tdap is given only once.

Measles (Rubeola)
Two doses measles (Rubeola) or provide serologic confirmation of immunity, unless born before 1957. (One dose on or after 12 months, second at least 30 days later. Must repeat vaccine if received even one day prior to 12 months of age.) If born before 1957, you do not need to be immunized.

Mumps One dose after12 months of age or provide serologic confirmation of immunity. History of disease is not acceptable.

Rubella (German Measles) One dose required, unless you provide serologic confirmation of immunity. History of disease is not acceptable.

VARICELLA: Chicken pox -Two doses or provide serologic confirmation of immunity. History of disease is not acceptable.

HEPATITIS B SERIES: Not required but strongly recommended.
3 doses: 1st dose, 2nd dose 1 month later, 3rd dose 5-6 months after the 2nd dose
The series should have been started before entering the clinical environment. Individuals who choose not to take the vaccine, must sign college declination form.

Flu Vaccine: Date of flu vaccine must be taken after September 1st and before October 31st.

Students should adhere to vaccine schedule for initial vaccines and updates as required by clinical agencies.

Students will not be allowed to attend clinical until immunizations are complete. Upon accumulating absences exceeding 10% of the contact hours, the student will be dropped from the class.

REPORT OF MEDICAL HISTORY *(Please print in black ink)* To be

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN NAME *SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo/day/yr)_____ GENDER ☐ M ☐ F MARITAL STATUS ☐ S ☐ M ☐ OTHER EMAIL_____

CLASS YOU ARE ENTERING:

PREVIOUSLY ENROLLED HERE ☐ YES ☐ NO
IF YES, DATES _____

PREVIOUSLY A PATIENT HERE ☐ YES ☐ NO
IF YES, DATES _____

SEMESTER ENTERING (circle): FALL SPRING

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

NAME OF POLICY HOLDER *SOCIAL SECURITY NUMBER

☐ ☐

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY & PERSONAL HEALTH HISTORY *(Please print in black ink)* To

Has any person, related by blood, had any of the following:

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

HEIGHT _____ WEIGHT _____

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack cigarettes/week			
Regularly exercise			
Wear seat belt			
Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED (Please print in black ink). To

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION….PLEASE READ AND

STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

Signature of Student **Date**

Signature of Parent/Guardian, if student under age 18 **Date**

IMMUNIZATION RECORD	**(Please print in black ink) To be completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.**

Last Name First Name Middle Name	Date of Birth (mo/day/year)	*Social Security #

SECTION A REQUIRED IMMUNIZATIONS

	mo/day/year (#1)	mo/day/year (#2)	mo/day/year (#3)	mo/day/year
• Tdap (Tetanus-Diphtheria-Pertussis) Tdap - One dose • Td- (Clinical agencies require one vaccine every ten years)				
• MMR (after first birthday)				Titer Date & Result Attach lab result.
• MR (after first birthday)				Titer Date & Result Attach lab result.
• Measles (after first birthday) (Clinical agencies require proof of vaccine or titer only)				Titer Date & Result Attach lab result.
• Mumps (Clinical agencies require proof of vaccine or titer only)				Titer Date & Result Attach lab result.
• Rubella (Clinical agencies require proof of vaccine or titer only)				Titer Date & Result Attach lab result.
• Hepatitis B series only OR Hepatitis A/B combination series				Titer Date & Result Attach Lab Report
• Varicella (chicken pox) series of two doses or immunity by positive blood titer. (Clinical agencies require proof of vaccine or titer only.)				Titer Date & Result Attach lab report
• Tuberculin (PPD) Test Date Read (within 12 months) mm induration				
• Chest x-ray, if positive PPD Date Results Treatment if applicable Date				

SECTION B RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students.

Meningococcal	Received the meningococcal vaccine? No ☐ Yes ☐
If Yes, please indicate date(s) vaccine was received (mo/day/year)	

SECTION C OPTIONAL IMMUNIZATIONS	mo/day/year	mo/day/year	mo/day/year
• Pneumococcal			
• Hepatitis A series only			

Signature or Clinic Stamp REQUIRED:

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

_____

Office Address **City** **State** **Zip code**

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** Must repeat measles vaccine if received even one day prior to 12 months of age.

*** Only laboratory proof of immunity to measles, mumps, rubella and varicella is acceptable if the vaccine is not taken. (If born before 1957, see note page 2).

PHYSICAL EXAMINATION *(Please print in black ink)*

A physical examination is required and must be completed in black ink and signed by a physician or clinic.

Last Name First Name Middle Name	Date of Birth (mo/day/year)	*Social Security Number

Permanent Address City State Zip Code	Area Code/Phone Number

Height _____ Weight_____ TPR _____/_____/_____ BP _____/_____

REQUIRED:

Vision: Corrected Right 20/ _____ Left 20/ _____

Uncorrected Right 20/ _____ Left 20/ _____

Color Vision _____

Hearing: (gross) Right _____ Left _____

15 ft. Right _____ Left _____

Optional:

Urinalysis :

Sugar:_____ Albumin:_____

Micro_____

Hgb or Hct_____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
Explain _____

D. Is student physically and emotionally healthy? Yes _____ No _____
Explain _____

• For Students Admitted to an Allied Health program•

Based on my assessment of this student's physical and emotional health on (Date)_____,
he/she appears able to participate in the activities of a health profession in a clinical setting.
Yes_____ No_____ if no, please explain _____
_____

_____ _____
Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____
Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

_____
Office Address **City** **State** **Zip Code**

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