Allied Health Division

Health History and Physical Exam

Student Name and ID#

Program of Study and Faculty Advisor

STUDENT MEDICAL FORM CHECKLIST

Completed forms MUST be housed in third party medical record repository(s) or be on file with the program.

1. Report of Medical History and Family & Personal Health History (pages 3 and 4)
*Must be completed by the student, signed, and provided to the health care provider during the physical exam.

2. Physical Examination (page 5) must be completed - Statement of student's physical and mental/emotional health must be completed, dated, and signed by physician, physician's assistant (PA), or family nurse practitioner (FNP) and/or have an agency stamp.

3. Allied Health students must provide official documentation of receiving the following vaccinations/tests. These will be uploaded into either a third-party medical record repository or given to the program administration.

IMPORTANT - Students MUST adhere to the immunization/vaccine requirements and updates as required by clinical agencies in order to participate in required clinical orientations, observations, and clinical courses. Completion of clinical courses with a grade of "C" or better is a graduation requirement.

Acceptable Records of Your Immunizations May be Obtained from Any of the Following
Be certain that your name, date of birth, and student ID appear on each uploaded vaccine record. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. Records are typically housed in one or more of the following:

- Primary school records (Board of Education) - 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 stamp
- Local health department or healthcare facilities where you may be employed
- Military records or WHO (World Health Organization) documents
- Previous college or university-Immunization records do not transfer automatically; you must request a copy

PPD: Two-step (2 sticks/2 reads) Tuberculin Skin Test or QuantiFERON Gold (QFT) also called T-spot blood test: Required annually. If a student has a history of being reactive to the skin test for any reason, a negative chest x-ray is required, addressing the absence of tuberculosis.

Tdap (Tetanus-Diphtheria-Pertussis): A Tdap or Td booster must be repeated every 10 years.

Measles (Rubeola): Two doses measles (Rubeola) or provide serologic confirmation of immunity, unless born before 1957 (one dose on or after 12 months of age, 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 after 12 months of age or provide serologic confirmation of immunity. Rubella (German Measles) One dose required, unless you provide serologic confirmation of immunity. These three vaccines are typically provided as one vaccine, administered twice during childhood.

VARICELLA: Chicken pox -Two doses or provide serologic confirmation of immunity.

HEPATITIS B SERIES: Not required but strongly recommended. There are 3 doses: 1st dose, 2nd dose 1 month later, 3rd dose, 5-6 months after the 2nd dose. There is also a two-dose vaccine that is acceptable in lieu of the three-dose called HEPLISAV-B. HEPSAV-B doses are administered one month apart. The series should be started before entering the clinical environment. Individuals who choose not to take the vaccine or are "in process," must sign a college declination waiver. Those "in process" will upload their series documentation when complete.

Flu Vaccine: Is required annually. For those with allergies, there are egg and preservative free versions available.

The COVID series or bivalent vaccine is required by the majority of program clinical sites. Some clinical sites may allow a religious or medical waiver in lieu of the vaccine(s) from the college and/or work with the student internally.

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*Rabies vaccination (pre-exposure prophylaxis or PrEP): Two-doses seven days apart - Veterinary students only

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

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN NAME

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo/day/yr)_____ EMAIL_____

PROGRAM YOU ARE ENTERING

PREVIOUSLY ENROLLED HERE ☐ YES ☐ NO

IF YES, DATES _____

SEMESTER ENTERING (circle): FALL SPRING

SUMMER 1 SUMMER 2 OTHER YEAR 20____

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

NAME OF POLICY HOLDER *Last Four SS#

POLICY OR CERTIFICATE NUMBER GROUP NUMBER IS THIS AN HMO/PPO/MANAGED CARE PLAN? ☐ YES ☐

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

FAMILY & PERSONAL HEALTH HISTORY *(Please print in black ink)* *To be completed by student*

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 _____

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED *(Please print in black ink) To be completed by student*

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? If yes, specify when, where, and why.			
Has your academic career been interrupted due to physical or emotional problems? If yes, please explain.			
Is there loss or seriously impaired function of any paired organs? If yes, please describe.			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? If yes, please describe.			
Have you ever had any serious illness or injuries other than those already noted? If yes, please specify when and where and provide details.			

IMPORTANT INFORMATION…. PLEASE READ AND COMPLETE

STATEMENT BY STUDENT:

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 ONLY be shared with programmatic administrators and clinical agencies where internships occur with the exception of a medical emergency. Should I become ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the program administrator of Asheville Buncombe Technical Community College to release information from my medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care if needed and/or requested.

_____ _____

Signature of Student **Date**

_____ _____

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

PHYSICAL EXAMINATION *(Please print in black ink)*

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

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

Permanent Address City State Zip Code	Area Code/Phone Number

Height_____ Weight_____ TPR_____/_____/_____ BP_____/_____

REQUIRED:	**Optional:**
Vision: Corrected Right 20/_____ Left 20/_____ Uncorrected Right 20/_____ Left 20/_____ Color Vision _____ Hearing: (gross) Right_____ Left _____ 15 ft. Right_____ Left _____	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 (as well as self-reported medical history and the functional abilities required of this profession) on (Date)_____, he/she appears able to participate in the activities of a _____.
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**