

Union County College – Respiratory Care Program – Student Health Form

NOTE: All areas must be completed

Name: _____
Date of Birth: _____
Sex: Male Female
Address: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Personal Health Overview (completed by student):

Identify any current health problems:

Medications taken:

Known Allergies:

Physical Examination (completed by Licensed Physician or Nurse Practitioner):

Physical examination completed (Date): _____

Limitation in physical activity? Yes No

If yes, please explain:

The student is able to participate in clinical patient care activities without restrictions: Yes No

If no, please explain specific restrictions:

Laboratory:

Laboratory Test	Date	Within Normal Limits
CBC	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinalysis	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Chemistry/Metabolic Panel	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

****Any abnormalities found require documentation by the provider and approval to participate in the program indicated. A positive drug screening may interfere with your ability to go to the clinical sites.***

Union County College – Respiratory Care Program – Student Health Form

Immunizations:

Blood titer levels need to be completed! Receipt of vaccine or history of the disease does not demonstrate immunity status. After any vaccines are received, a follow-up blood titer may be done to determine immunity. Actual blood values and immunity status for each titer must be entered by the healthcare provider.

Vaccine	Date Received	Immunity Status	Follow-up Titers	Blood Values
Measles	_____	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mumps	_____	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Rubella	_____	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Varicella	_____	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis B	1 st dose	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
	2 nd dose	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
	3 rd dose	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Hepatitis C:

Positive Negative

Vaccine

Date Received

Flu Vaccine (Annual Requirement) _____

Tetanus, Diphtheria, Pertussis Vaccine* _____

*Receipt of vaccine must be within 2 years of the date on this form

Urine Drug Screening with confirmation

Date: _____ Positive Negative

Note: If vaccines are declined, signed copies must accompany this form. Students who are not immune to the infectious diseases noted may be prohibited by the clinical agencies from participating in clinical experiences in areas where disease transmission poses a high risk to patients, staff, visitors and or students.

Two-Step Mantoux Test**

Mantoux testing, chest x-ray or pulmonary clearance is required on an annual basis.

Test	Date	Results
Two-Step Mantoux	_____	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Chest X-Ray	_____	Results: _____
		Medication: _____
Pulmonary Clearance (attach forms)	_____	

** A two-step Mantoux is not required if documentation is provided of a negative Mantoux within 12 months of the date noted by the healthcare provider. Students who have positive Mantoux tests or who are not able to take the Mantoux (prior receipt of BCG) are required to have chest x-rays or pulmonary clearance from the healthcare provider

 Examiner's Name, Credentials, License #, Address (Official Stamp **REQUIRED**)

 Examiner's Signature (**REQUIRED**)

 Date