Health Services Student Medical Form

Full Name: _____ Date Submitted: _____

Student Medical Form for

(Please check **one program applying for**)

- ☐ Associate Degree Nursing
- ☐ LPN-RN Bridge
- ☐ Dental Hygiene
- ☐ Health Information Technology
- ☐ Healthcare Management Technology
- ☐ Medical Office Administration
- ☐ Radiography
- ☐ Respiratory Therapy
- ☐ Surgical Technology

Continuing Education classes

- ☐ CNA
- ☐ Computed Tomography
- ☐ Dental Assisting Certificate
- ☐ Dental Health Coordinator
- ☐ EKG and Basic Cardiology
- ☐ Medical Assisting
- ☐ Medication Aide
- ☐ Pharmacy Technician
- ☐ Phlebotomy

It is very important that you read and follow all directions in this packet. Make sure all information is completed before submitting your packet. Partial packets **will not** be accepted. Thank you.

Copies of records may be submitted, but all information must be completed, and a signature is required by the healthcare provider on all forms.

This Medical form packet must be completed upon admission and readmission.

Please make a copy of these forms for your records.

Personal Health History
(Please Print in black ink)

Personal Information
To be completed by student

Last Name _____ First Name _____ Middle/Maiden _____

CVCC (Catawba Valley Community College) ID Number _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Date of Birth (mo./day/yr) _____ Gender ☐ M ☐ F

Marital Status ☐ S ☐ M ☐ Other Email _____

Hospital/Health Insurance _____

Address of Insurance _____ Phone Number (___) _____

Name of Policy Holder _____ Employer _____

Policy or Certificate Number _____ Group Number _____

Is this an HMO/PPO/Managed Plan? ☐ Yes ☐ No

Emergency Contact Information
Name of Contact _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone Number (___) _____

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

Personal History
Height _____ Weight _____

Have you ever had or have you now:
(If yes, indicate the year of first occurrence)

Condition	Yes	No	Year
High blood pressure			
Heart conditions			
Asthma			
Thyroid			
Diabetes			
Serious skin disease			
Arthritis			
History of concussion or severe head injuries			
Dizziness or fainting spells			
History of spinal injuries			
Blood disorder			

Condition	Yes	No	Year
Hernia			
Hepatitis			
Seizures			

Medications
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.

Number	Name	Use	Dosage
1			
2			
3			
4			
5			
6			
7			
8			

Allergy/Adverse Reaction Information
Check each item “Yes” or “No.” Every item checked “Yes” must be fully explained in the space to 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.

Allergies/Adverse Reaction To	Yes	No	Name	Explanation of Symptoms
Antibiotics				
Pain Medication				
Latex				
Insect Bites				
Food				

Additional Questions
Do you have any conditions or disabilities that limit your physical activity? ☐ Yes ☐ No

(If yes, please describe)

_____

Do you carry an EpiPen? ☐ Yes ☐ No

Student Statement

Important information. Please read and complete. Statements are to be completed by student (or parent/guardian if student is under age 18).

I have personally provided 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 (child’s) medical record to a physician, hospital, or

other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

I, the undersigned student in a health program at Catawba Valley Community College, understand that participation in a clinical setting is a requirement to complete my program successfully.

Please initial that you understand each requirement and have had your questions answered regarding these requirements.

_____Criminal Background check upon acceptance/registration following program specific requirements and annually thereafter

_____Obligation to report criminal charges.

_____Obligation to report any changes in health status.

_____Drug testing upon acceptance/registration following program specific requirements and annually thereafter.

_____Healthcare provider signed form/Physical and emotional stability.

_____Obtain and maintain all clinical requirements, annual immunizations, and vaccines in CastleBranch as instructed by the health program.

Signature of Student _____ Date _____

Signature of Parent/Guardian (if student is under 18) _____ Date _____

Authorization for off-campus clinical release

Authorization for Disclosure: Off-campus/Clinical Facility Release of Student Health Information Off-campus clinical facilities may require medical information on students in programs with clinical assignments. Catawba Valley Community College is responsible for providing the clinical facility with medical data abstracted from the student's medical record. This data may include vaccinations received, medical test results, criminal background screens and drug screen results. The facility may also require that the student provide a copy of their medical packet, if necessary, including emergency contact information for first aid and safety purposes if medical treatment is required.

By signing below, I authorize Catawba Valley Community College and the School of Health Education to release and disclose any and /or all pertinent medical information as indicated in the above provision, to an affiliating clinical facility that require this information as a condition of my assignment to the facility. I understand that if I refuse to release my medical information to Catawba Valley Community College /clinical facilities I may lose my eligibility to continue as a student in Catawba Valley Community College Health Programs. I further understand that failure to release the records may result in the facility denying my clinical assignment. I also understand that I may not be able to fulfill the Program's graduation requirements.

Signature of Student _____ Date _____

Signature of Parent/Guardian (if student is under 18) _____ Date _____

The following Immunization record and Physical Examination must be completed and signed by Physician or Clinic

Immunization Record

Please print in black ink. A complete immunization form may be attached to this form.

Last Name _____ First Name _____ Middle/Maiden _____

Date of Birth (mo./day/yr) _____ CVCC ID Number _____

Guidelines for Completing Immunization Record

Important – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit. Immunization records must include name, date of birth, **and** vaccine administration (must include the month, day, and year).

Acceptable records of your immunizations must be obtained from any of the following:

- **High School Records** – These may contain some, but not all, of your immunization information. Your immunization records do not automatically transfer. You must request a copy.
- **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 automatically transfer. You must request a copy.

Required Immunizations

Immunization	Dose 1 (Mo/Day/Yr)	Dose 2 (Mo/Day/Yr)	Dose 3 (Mo/Day/Yr)	Titer date and results
Tdap (one dose as adult) then Td every 10 years				Titer not applicable
MMR Proof of 2 doses OR positive titer				Lab report required (attach)
Varicella (chicken pox) Proof of 2 doses OR immunity by positive blood titer				Lab report required (attach)
Hepatitis B (3 shot series only) OR Heplisav-B (2 doses 4 weeks apart) OR immunity by positive blood titer. **Please refer to your specific program guidelines on which Hep B shot is accepted.**				Lab report required (attach)
Covid-19 vaccination (2 dose Pfizer or Moderna OR 1 dose Johnson & Johnson) No exemptions accepted.				Titer not applicable
Influenza (annually administered during Sept – Oct of the current year)				Titer not applicable

2-Step Tuberculin (PPD) Skin Test OR *QuantiFERON-TB Gold

<u>*Please refer to your specific program guidelines on the required Tuberculin (PPD) Skin Test and administration dates.</u> (Within 6 months of program start date)

TB Step	Test administer date	Date Read	mm Induration
1			
2			

Chest X-Ray, if positive PPD (date) _____

Results _____

Treatment, if applicable _____

QuantiFERON-TB Gold	Test administer date	Results

Physical Examination

Please print in black ink.

To be completed and signed only by a physician or clinic.

A physical examination is required by some schools and/or programs. Consult your college or department for specific requirements. If required, it must be completed in black ink and signed by a physician or clinic.

Last Name _____ First Name _____ Middle/Maiden _____

Date of Birth (mo./day/yr) _____ CVCC ID Number _____

Address _____ City _____ State _____ Zip _____

Phone Number _____

Height _____ Weight _____ TRP _____/_____/_____ BP _____/_____

Vision

Corrected: Right 20/____ Left 20/____

Uncorrected: Right 20/____ Left 20/____

Color Vision: _____

Hearing

Gross: Right _____ Left _____

15 ft: Right _____ Left _____

Abnormalities

Are there abnormalities?	Normal	Abnormal	Description (attach additional sheets, if necessary)
Head, ear, nose, throat			
Eyes			
Respiratory			

Are there abnormalities?	Normal	Abnormal	Description (attach additional sheets, if necessary)
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Mammary			
Blood conditions/disorders			

Is there loss of seriously impaired function of any paired organs? Yes ☐ No ☐
Explain _____

Is the student under treatment for any medical or emotional condition? Yes ☐ No ☐
Explain _____

Does the student have conditions or disabilities that limit their physical activity? Yes☐ No ☐
Explain_____

Does the student have any documented history of drug or alcohol abuse? Yes ☐ No ☐
Explain_____

Is the student physically and emotionally healthy? Yes ☐ No ☐
Explain _____

For Students Admitted to a Health Service Program

To be completed and signed only by a physician or clinic. Non-completion will result in returning the health form to the student to return to healthcare provider for completion.

Based on my assessment of this student's physical and emotional health and with the understanding of the student's selected healthcare field 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/PA/Nurse Practitioner _____ Date _____

Print Name of Physician/PA/Nurse Practitioner _____

Address _____ City _____ State _____ Zip _____

Phone Number (___) _____