



# Health Occupation Programs History and Physical Examination Form

Name

**(To Be Completed by the Student)**

**Program:** (Check One)

- |  |   |   |
|--|---|---|
| <input type="radio"/> Associate Degree Nursing   | <input type="radio"/> Dental Hygiene        | <input type="radio"/> DM Sonography                 |
| <input type="radio"/> Massage Therapy            | <input type="radio"/> Medical Assistant     | <input type="radio"/> Medical Lab Tech              |
| <input type="radio"/> Nursing Assistant          | <input type="radio"/> Phlebotomy            | <input type="radio"/> Practical Nursing             |
| <input type="radio"/> Physical Therapy Assistant | <input type="radio"/> Radiologic Technology | <input type="radio"/> Respiratory Care Practitioner |
| <input type="radio"/> Surgical Technology        |   |   |

**Student Name:** \_\_\_\_\_  

Last
First
Middle
Maiden

**Address:** \_\_\_\_\_  

Street
City
State
Zip Code

**Phone:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_  

Home
Work
Cell
MM
DD
YYYY

**Emergency Contact:** \_\_\_\_\_  

Name
Relationship
Phone
  

Street
City
State
Zip Code

**Check the appropriate answer to each of the following:**

- |       |       |                               |       |       |                     |
|-------|-------|-------------------------------|-------|-------|---------------------|
| Yes   | No    |                               | Yes   | No    |                     |
| _____ | _____ | Rheumatic Fever               | _____ | _____ | Heart Disease       |
| _____ | _____ | Emotional Disorder/Disability | _____ | _____ | Back Injury         |
| _____ | _____ | Color Blind                   | _____ | _____ | Hemophilia          |
| _____ | _____ | Diabetes                      | _____ | _____ | Asthma              |
| _____ | _____ | Allergies to Latex**          | _____ | _____ | Epilepsy/Seizures** |

\*\*If Yes, Please See Health Services\*\*

Please specify all allergies: \_\_\_\_\_

**Please read carefully and sign:**

I understand that there are conditions for which accommodations may be appropriate under the Americans with Disabilities Act and that the Health Occupation Programs will make all reasonable accommodations required by law for otherwise qualified individuals. To receive accommodations, I must contact the Office for Students with Disabilities.

I understand that any health care costs incurred during the period of time I am a student in the Health Occupation Programs will be my responsibility.

I hereby grant Lake Superior College permission to share information contained in the Health Examination and Immunity Requirement forms with those clinical institutions with whom I affiliate in my student role, should the clinical institution request or require it.

I understand that failure to sign this form or to provide the information requested in the Health Examination and Immunity Requirement forms could mean that a clinical site may refuse me placement at their facility. The Health Occupational Programs do not guarantee an alternative facility placement. I also understand that if no alternative facility placement is available, I may be terminated from the Health Occupational Programs.

\_\_\_\_\_  

Student's Signature
Month
Day
Year

The immunizations required are standards set by the Minnesota Department of Health & Human Services Centers for Disease Control and Prevention

**(To be completed by a health care provider\* or attach official immunization records)**

\*Health care provider is defined as a doctor's office, school, military, prior employer or other official source of vaccine information

Required Immunizations	Dates Immunizations Received <i>OR</i>			Antibody Titre
<b>Measles (Rubeloa)</b> Report 2 doses after age 12 months <i>or</i> Titre date & results <b>*2 Doses are required*</b>	Dose 1 Date  ____ / ____ / ____ MM DD YYYY	Dose 2 Date  ____ / ____ / ____ MM DD YYYY		Date  ____ / ____ / ____ MM DD YYYY  Results
<b>Mumps</b> Report 2 doses after age 12 months <i>or</i> Titre date & results <b>*2 Dose are required*</b>	Dose 1 Date  ____ / ____ / ____ MM DD YYYY	Dose 2 Date  ____ / ____ / ____ MM DD YYYY		Date  ____ / ____ / ____ MM DD YYYY  Results
<b>Rubella (German Measles)</b> Report 1-2 doses after age 12 months <i>or</i> Titre date & results <b>*Only 1 dose is required*</b>	Dose 1 Date  ____ / ____ / ____ MM DD YYYY	Dose 2 Date  ____ / ____ / ____ MM DD YYYY		Date  ____ / ____ / ____ MM DD YYYY  Results
<b>Hepatitis B</b> Report 3 doses <i>or</i> Titre date & results <i>or</i> Signed Waiver	Dose 1 Date  ____ / ____ / ____ MM DD YYYY	Dose 2 Date  ____ / ____ / ____ MM DD YYYY	Dose 3 Date  ____ / ____ / ____ MM DD YYYY	Date  ____ / ____ / ____ MM DD YYYY  Results
<b>Varicella (Chicken Pox)</b> Self Report of Disease History <i>or</i> Report 2 Doses <i>or</i> Titre date & results	<b>Self Report of Disease (Circle)</b> <b>Yes / No</b> If yes, stop here If no, continue with vaccine doses	Dose 1 Date  ____ / ____ / ____ MM DD YYYY	Dose 2 Date  ____ / ____ / ____ MM DD YYYY	Date  ____ / ____ / ____ MM DD YYYY  Results
<b>Tetanus/Diphtheria (Td)</b> Report most current dose <b>*Must be within 10 years*</b>	Dose Date			
<b>Pertussis (Whooping Cough) (Tdap)</b> <b>*Only 1 dose is required*</b>	Dose Date			
<b>Mantoux (Tuberculosis)</b>  <b>*Required Annually*</b>	Please <b>attach official documentation</b> from the agency where test was completed to this form. A Chest X-Ray & documentation is required if your Mantoux results are positive. Mantoux tests can also be given and read at LSC Health Services for a minimal fee.			

If student is pregnant and vaccinations are needed to meet immunity requirements, they **MUST** be received after delivery. If pregnant, please indicate: Due Date: \_\_\_\_\_

Signature of Health Care Provider

Date

Organization

*Signature not required if official immunization records are attached.*



**Immune Status:** Health Occupation students are assigned in clinical areas where exposure to infection and communicable disease is common. Is the student's immune response or status sufficient to allow assignment in all clinical areas and to all patients (assuming use of protective measures ordered by the facility)?

**Check appropriate response:**

\_\_\_\_\_ Yes  
\_\_\_\_\_ No

If the student's immune response or status is not sufficient to allow assignment in all clinical areas and to all patients (assuming use of protective measures ordered by the facility), please state below:

1. The condition(s) and/or treatment which make the student vulnerable to infection
2. If there is a:
  - a. permanent problem
  - b. temporary problem. If so, state date when student may be exposed to pathogens commonly found in a hospital setting.
  - c. episodic problem. If so, describe the student's current status.

**Comment(s):**

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**Examiner:**

I certify that this individual's immunizations are current and he/she does not have any health problems which would jeopardize either the student's welfare or patient's welfare and does not have any limitations which would restrict them from performing the customary duties of a health occupation student/employee.

\_\_\_\_\_  
(Signature of Examiner) (Credential) Date \_\_\_\_\_

\_\_\_\_\_  
(Name of Examiner – Printed) (Credential – Printed)

\_\_\_\_\_  
(Clinic Name and Address) (Clinic Phone Number)

**DO NOT SIGN BELOW UNTIL ONE (1) YEAR AFTER YOUR PHYSICAL**

**One Year Update**

\_\_\_\_\_ There **have not** been any changes in my health status in the past twelve (12) months.

\_\_\_\_\_  
Student's Signature Date

**OR**

\_\_\_\_\_ There **have** been changes in my health status in the past twelve (12) months.

Please provide recent exam/report from physician.

**\*\*Student must inform program of any changes in health status as they occur\*\***