# Health Science Programs

# Medical Evaluation Physical and Immunization Review

_____

(Program Name)

_____

(Print Your Name)

*** Disclaimer:** The health history and physical of any student **IS NOT** used as criteria for acceptance into any Health Sciences program.

***Students – please complete all highlighted fields prior to your examination with your provider.***
***Thank you!***

# Hawkeye Community College Health Science Medical History

***To be completed by the student.***

**Name** _____ **Student ID**_____

**DOB**_____/_____/_____ **Program**_____

**Address**_____ **Telephone**_____

**Emergency Contact** _____ **Address** _____

**Telephone**_____

| Have you ever had/currently have? | Yes | No | Comments |
|---|---|---|---|
| Heart Disease (High Blood Pressure) | | | |
| Diabetes | | | |
| Respiratory Disorder (Asthma, TB) | | | |
| Ear, Nose, Throat Problems (Assistive Hearing Device) | | | |
| Psychological or Emotional Disorder | | | |
| Convulsive/Seizure Disorder | | | |
| Hepatitis, Liver Disease | | | |
| Disease or Injury of Joints | | | |
| Back Problems or History of Back Problems | | | |
| Has your physical activity ever been restricted? (please give reason/duration) | | | |
| Do you have any physical limitations that restrict activity and/or require special adaptation(s)? | | | |
| Have you had any serious illness or injury, or been hospitalized other than already noted? Give details. | | | |
| Do you have or are you a carrier of any Infectious disease which poses a health or safety risk to you or others? (If yes, explain and provide statement from healthcare provider under which conditions you can't participate) | | | |
| Do you have any condition that would restrict activity and/or require special adaptation(s)? | | | |
| Are you currently being treated by a healthcare professional for any condition(s)? | | | |
| Are you taking any medications regularly or as needed? (Other than aspirin/ibuprofen/Tylenol) | | | List of Medications: |
| Allergies/sensitivities (latex, medications, environmental, food) | | | List of Allergies: |

**Over the last two weeks, how often have you been bothered by the following problems?**

***Chart to be completed by student.***

| | Not At All | Several Days | More Than Half the Days | Nearly Everyday |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| TOTALS | | | | |

**If there is a change in this information, I will notify my instructor.**

**Student Signature** _____ **Date**_____

## Vaccination Disclosure

As a patient safety and health care personnel safety initiative, certain programs or departments require vaccinations for students and clinical instructors. Medical facilities contracting with Hawkeye Community College that require all healthcare personnel to be vaccinated may not grant access to clinical experiences for unvaccinated individuals due to patient health and safety. By signing below:

a. I acknowledge that I may have a limited ability to complete my clinical experiences which may financially impact me, materially affect or prevent my ability to fulfill the requirements of my course of student, and/or materially affect or prevent me from obtaining a desired licensure or credential.
b. I am required to comply with all requirements requested by the various clinical sites in my clinical rotations, subject only to reasonable accommodations requested and granted consistent with applicable law.

**Student Name:** _____ **DOB:** _____ /_____ /_____

**Student Signature:** _____ **Date:** _____

# Tuberculosis Screening Form

**Name:** _____ **DOB**_____ /_____ /_____ **Today's Date:** _____

## Section 1: Tuberculosis Symptom Screening

***Have you had now or in the past experienced the following symptoms?***

A productive cough for more than a three (3) week duration? _____Yes _____No

Coughing up blood? _____Yes _____No

Persistent fevers? _____Yes _____No

Drenching night sweats? _____Yes _____No

Unexplained weight loss? _____Yes _____No

Have you been in close contact with a person with infectious TB disease? _____Yes _____No

Have you immigrated from a part of the world with high rates of TB? _____Yes _____No

## Section 2: Tuberculosis Risk Screening

Birth Country: _____ If not born in the US, when did you come to live in the United States? (month/year) _____/_____

In the last year, have you spent more than 30 days outside of the United States?

If yes, where? _____ Length of stay? _____

Do you have documentation of a single TB Skin Test being done in the last 12 months that can be/has been submitted to CastleBranch?

_____Yes _____No (If yes, when was the TB test? _____)

Do you have documentation of a 2-Step TB Skin Test being done once in your lifetime that can be/has been submitted to CastleBranch?

_____Yes _____No (If yes, when was the 2-Step TB Test? _____)

Have you ever had a **POSITIVE** Tuberculosis Test of any type? _____Yes _____No (If yes, when? _____)

Did you have a chest x-ray? _____Yes _____No (If yes, where? _____)

Did you take medication? _____Yes _____No

**Provider Comments:** _____

## Section 3: Tuberculosis Testing Requirements

- **Documentation of a 2-Step TST test done once in your lifetime.**
  - 2-Step TST Test - Two separate TST tests read within 48-72 hours after each test. If the first-step TST result is negative, the second stage of the two-step TST is recommended one to three weeks after the first TST result was read. Administration of the second stage of the two-step TST shall not exceed 12 months after the first TST result was read.
- **If the TST test result is + (positive**) then a QuantiFERON Gold blood test and/or chest X-ray will be required. After the initial 2-step testing, an annual TB test will be required**.**
- **An annual TB Test is required if > than 12 months since initial 2-Step TST Screen**.

| | Date/Time Placed | R/L arm | Signature of Provider | Date/Time Read | Results mm | Pos./Neg. | Signature of Provider |
|---|---|---|---|---|---|---|---|
| **Test #1** | | | | | | | |
| **Test #2** | | | | | | | |

☐ Test #2 not applicable secondary to the criteria listed above.

# Hawkeye Community College Immunization Record

**Student Name: _____ Student ID: _____ Program: _____**

****Students: Please bring your immunization record, and/or titer lab results with you to your physical exam, including any handwritten documents. This will help your healthcare provider review the following immunization information.**

| Vaccine: | Series: | Provider Review Findings: |
|---|---|---|
| Hepatitis B: Documentation of 3 doses of vaccine | Hepatitis B #1 | |
| | Hepatitis B #2 | |
| | Hepatitis B #3 | |
| **OR** Hepatitis B Titers | | |
| MMR (Measles, Mumps, Rubella): Documentation of 2 doses of vaccine. (Not required if born prior to 1957) | MMR #1 | |
| | MMR #2 | |
| **OR** MMR Titers | | |
| Varicella (Chicken Pox): Documentation of 2 doses of vaccine | Varicella #1 | |
| | Varicella #2 | |
| **OR** Positive Varicella-Zoster Immune Globulin (VZIG) Titer **OR** date of documented varicella month and year. | | |
| Tdap (Tetanus, Diphtheria, Pertussis): Documentation of 1 Dose of Tdap required, **AND** then Td **OR** Tdap booster every 10 years. | Tdap | |
| | Booster Dose | |
| COVID-19 Bivalent mRNA Vaccine *(4/18/2023)* | COVID-19 Bivalent mRNA | Vaccine: _____<br>Date: _____ |
| Candidate for COVID-19 Bivalent mRNA Booster? | No<br>Yes - Condition: _____<br>_____ | Vaccine: _____<br>Date: _____ |
| Seasonal Influenza Vaccine | Influenza | |

# Hawkeye Community College Physical Exam

**Student Name: _____Student ID: _____ Program: _____**

***To be completed by a physician, nurse practitioner, or physician assistant. The physical exam must not be older than one (1) year prior to the start of the program.***

Vitals (per provider's discretion) T _____ HR _____ RR _____ B/P ____/____ HT____" ____ WT # _____

**Required** – Vision R 20/ _____ L 20/ _____ Corrected Y_____ N_____ Whisper Test R@ _____ft L @ _____ft

| **Clinical Evaluation** | **WNL (within normal limits)** | **Comments** |
|---|---|---|
| General Appearance | | |
| HEENT | | |
| Neck/Thyroid (ROM) | | |
| Lungs/Chest | | |
| Cardiovascular | | |
| ABD/GU/Hernia | | |
| Back/Spine (ROM, Tenderness, SLR) | | Lifting Restriction?<br>_____ Yes _____ No |
| Psych | | |
| Neurologic | | |
| Other findings | | |

If health conditions are present, do they create a limitation in the ability to provide health care? _____ Yes _____ No

Explain: _____

Does your examination reveal any active illness that would be a hazard to others? _____ Yes _____ No

Explain: _____

Historical immunization records have been reviewed with the patient by the provider.

Based on today's exam and the disclosed health history, this student does not have any health condition that would create a hazard to self and others or limit their ability to provide healthcare. In addition, this person is capable of performing the physical requirements of his/her program which can include bending, stooping, pushing, and lifting without weight restriction.

| **Agency or Clinic Name:** | |
|---|---|
| **Printed Name:** | **Title:** |
| **Signature:** | **Date of exam:** |