# Minnesota West Community and Technical College
# Health History & Physical Examination Form
### Allied Health and Nursing Students Only

This information is confidential and will not be released to anyone without the students' knowledge and consent. The cost of the physical/immunizations is the students' responsibility.

Student's Name:_____ID#_____

Street Address:_____

City:_____State:_____Zip_____Country:_____

Date of Birth (dd/mm/yyyy): _____/_____/_____ Sex: Male ____ Female____ Other:_____

**Identify your program of study** (**X**):

Nursing____ Occupational Therapy Assistant____ Radiology____ Surgical Technologist____

Medical Lab Technology ____ Medical Assistant _____ Dental Assistant _____ Phlebotomy ____

Pharmacy Tech _____ Community Health Worker _____

**Please circle if you have or have had the following:**

| | | | | | |
|---|---|---|---|---|---|
| Asthma | Yes/No | Epilepsy/Seizures | Yes/No | Psychiatric/Behavior Disorder | Yes/No |
| Cancer | Yes/No | Gastrointestinal Disorders | Yes/No | Pulmonary Disease | Yes/No |
| Cardiovascular Disease | Yes/No | Hepatitis/Jaundice | Yes/No | Skin Disease | Yes/No |
| Diabetes | Yes/No | High Blood Pressure | Yes/No | Tobacco Use | Yes/No |
| Drug/Alcohol Abuse | Yes/No | Kidney/Urinary Disorder | Yes/No | Other | |
| Endocrine Disorder | Yes/No | Musculoskeletal Disorder | Yes/No | Other | |

Please explain any YES answers above: _____

_____

List of Allergies: _____

_____

Surgeries and/or Previous Hospitalizations (with dates): _____

_____

Current Medications: _____

_____

I certify that all information contained in this document is true and complete to the best of my knowledge and agree that any misrepresentations or deliberate omissions of a material fact on this questionnaire may result in my not being permitted to enter the program or may result in termination.

Student Signature: _____ Date: _____

Student's Name:_____ID#_____

**GUIDELINES FOR REQUIRED IMMUNIZATIONS:**

**Measles (Red Measles, Rubeola)**

- Dates of **two** doses of measles or MMR vaccine **or**
- **Physician** diagnosis of disease **or**
- Report of immune titer proving immunity

**Mumps**

- Dates of **two** doses of mumps or MMR vaccine **or**
- **Physician** diagnosis of disease **or**
- Report of immune titer proving immunity

**Rubella (German Measles) – *Note: History of disease is not accepted***

- Dates of **two** doses of rubella or MMR vaccine **or**
- Report of immune titer proving immunity

| | Month/Year | Physician Diagnosed disease History (Date of onset) | Titers |
|---|---|---|---|
| **MMR Combined Vaccine OR** | #1. /<br>#2. / | | Laboratory Report with lab values MUST be attached |
| **Measles: Two Doses** | #1. /<br>#2. / | | Laboratory Report with lab values MUST be attached |
| **Mumps: One Dose** | | | Laboratory Report with lab values MUST be attached |
| **Rubella: One Dose** | | **Not Accepted** | Laboratory Report with lab values MUST be attached |

**Tdap (diphtheria, tetanus, and acellular pertussis) dated after 2005**

- The combined Tdap injection is required within the last ten years

| | Month/Year | Physician Diagnosed disease History (Date of onset) | Titers |
|---|---|---|---|
| **Tetanus/Diphtheria:** | | **Not Applicable** | **Not Applicable** |

**Hepatitis B**

- Dates of vaccination are a series of three doses. At minimum, this series must be started before beginning clinical experience **OR** report of positive antibody

| | Month/Year | Physician Diagnosed disease History (Date of onset) | Titers |
|---|---|---|---|
| **Hepatitis B: Three Doses of vaccine or 2 doses of the Heplisav-B** | #1. /<br>#2. /<br>#3. / | | Laboratory Report with lab values MUST be attached |

Student's Name:_____ID#_____

**Chicken Pox (Varicella)**

- Documented dates of vaccination or history of positive titer

| | Month/Year | Physician Diagnosed disease History (Date of onset) | Titers |
|---|---|---|---|
| **Varicella:** | #1. /<br>#2. / | | Laboratory Report with lab values MUST be attached |

**COVID 19 Vaccination – Per Facility requirement**

- Documentation must include the vaccine manufacturer and lot number

| | Month/Year | Physician Diagnosed disease History (Date of onset) | Titers |
|---|---|---|---|
| **COVID Vaccine**<br>Manufacturer:<br>Lot #: | #1. /<br>#2. /<br>/<br>/ | **Not Applicable** | **Not Applicable** |

**Influenza (flu) Shot – Excludes Dental Assisting Students**

- Documentation must be received between August 1 and October 1 on Influenza/Vaccination Administration form for Nursing/Allied Health Students and excludes Dental Assisting students.

| | Month/Year | Physician Diagnosed disease History (Date of onset) | Titers |
|---|---|---|---|
| **Annual Influenza** | | **Not Applicable** | **Not Applicable** |

**Tuberculin Test-** Tuberculin skin testing (TST) (Mantoux) or QuantiFERON (QFT)

- Baseline tuberculin skin test (TST) or QuantiFERON (QFT) and an assessment for current symptoms of active TB disease are required on all students unless they have a history of a previous positive TST.
- Proof of two TSTs within the previous 12 months is required for new students or proof of QFT.
- The first step of the TST must be read in 48-72 hours after the initial injection. Those who have a negative reaction to the first test will have a second TST planted one week after the initial test.
- A one-step TST will be administered if there is proof of one other test within the previous 12 months.
- TST or assessments are required annually.
- The TST is not done in the event any student has a known positive reaction. They must provide proof of a positive reaction and will need a chest X-ray within the last year and an assessment for current symptoms of active TB disease
- All students with a newly positive TST or QFT will be referred to their primary physician.

| | | | |
|---|---|---|---|
| **Annual Tuberculosis Testing:** | TST- Date Administered: | Date Read: | Result: |
| | #1. / | #1. / | |
| | #2. / | #2. / | |
| | QST- Date drawn: / | | Results: |

Student's Name:_____ID#_____

## Physical Examination

This form must be completed and signed by your physician, nurse practitioner, or physician assistant.

**Examiner:** Please review this individual's health history and then complete and sign this form. This information will be used as a background for providing health care when necessary. Please be advised that the cost of this examination must be assumed by the individual.

Height: _____Weight: _____ Vision: R ____/____ L____/_____ Hearing: Rt _____P/F Lt_____P/F

Temp: _____BP: _____/_____ Pulse: _____ Respirations: _____

**Are there any abnormalities/impaired functions/disease conditions of the following? If yes, please explain.**

| | Normal | Abnormal | Comments |
|---|---|---|---|
| H.E.E.N.T | | | |
| Neck/Thyroid | | | |
| Respiratory | | | |
| Cardiovascular | | | |
| Gastrointestinal | | | |
| Genitourinary | | | |
| Musculoskeletal | | | |
| Metabolic Endocrine | | | |
| Psychological | | | |
| Neurological | | | |
| Integumentary | | | |

**PHYSICIAN'S CERTIFICATION:**

I hereby certify that the above-named person is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risks to patients and other personnel or which may interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This individual is able to participate in their clinical learning experiences.

**Provider Please check**: _____CLEARED FOR PROGRAM _____NOT CLEARED FOR PROGRAM

Medical Provider: _____Date: _____

Medical Provider Name (print)_____License No._____

Medical Provider Stamp (required)_____Phone (____) _____

Address: _____

**Nursing Students:** Please upload all forms and lab reports to the CastleBranch website. www.castlebranch.com
**Allied Health Students:** Please turn all forms and lab reports to your program director or program faculty.