# Randolph Community College

# Student Medical Form for Programs that Require Health Forms

**Randolph Community College**
**Health Science Division**
**Robert S. Shackleford Allied Health Center**
**606 Industrial Park Avenue**
**Asheboro, NC 27205**

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Welcome to Randolph Community College! We are glad you have chosen to complete your education here in one of our Health Science programs.

The Student Medical Form is required by clinical agencies for students to be able to participate in clinical experiences. Each program will indicate to students when these forms are to be completed. It is expected that the student will submit an honest and accurate record. Omissions, whether intentional or not, may impact the acceptance and/or approval of your admission.

Once the Medical Form is completed and submitted to the program, **the student is responsible for notifying the program <u>in writing</u> of ANY changes to the Medical Form within 5 business days of the change (i.e. injury, pregnancy or other condition that could affect participation in clinical). Such changes may require an additional attestation by a physician or health care provider of your ability to participate in clinical.** Failure to follow these procedures may lead to the student's inability to participate in clinical.

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## Students should follow these guidelines when completing the Student Medical Form:

- Each program will notify the student when this form is due. Failure to submit the information by the due date may result in the inability to progress in the program or dismissal from the program.
- Refusal to obtain required immunizations (or titers) may result in the inability to progress or dismissal from the program.
- This form should be completed no more than six (6) months (or longer if indicated) before the student begins the clinical program by the physician, physician's assistant or nurse practitioner familiar with the student and his/her medical history.
    - If you are being treated for any medical or mental condition that requires continued treatment or monitoring, you MUST have the physician who is treating you fully complete the Physical Examination and the Required Medical Assessment section on the form.
    - If you are not being treated currently for a medical condition, you may have any physician complete the medical part of the form.
- Be sure that the physician, physician's assistant, or nurse practitioner completes the immunization record and physical examination forms **and** he/she **SIGNS (not a signature stamp)** and dates the form. The form also requires an official office stamp in addition to the signature and date.
- The Immunization Record is extremely important. To avoid problems completing this information, read the Guidelines for Completing Immunization Record (see page 2). If you have any questions, please refer them to the Clinical Coordinator and/or Department Head for the program.
- If the student is not continuously enrolled (i.e. is not enrolled for a consecutive Spring and Fall semester), then the student must obtain a new medical form for the program.

Instructions for Completing the Student Medical Form:

1. Make an appointment with your primary care provider, or health care provider.
2. Student completes Form A: Personal Information
3. Form B: Medical Form Review Attestation by Student.
4. Primary care provider, or health care provider completes Form C: Immunization Record and Form D: Physical Examination
5. Ensure that the health care provider signs and the clinic stamp is noted on the form.

When the Medical Form is complete, the ***student should make a copy for his/her personal records.*** Please **SIGN** this form which is to be submitted with the original medical form to the program. Please contact the Clinical Coordinator and/or Department Head and/or Administrative Assistant for Health Science Programs for the program in which you are applying, if you have any questions.

**I am submitting this completed Medical Form and attest that it is true and complete to the best of my knowledge. I understand that if anything on this form changes while I am a student in a health program, I must notify the program director in writing within 5 business days of the change.**

**I understand the Randolph Community College's Health Programs will share health and immunization information with appropriate clinical agencies for onboarding processes or in the event of a medical emergency.**

Health and immunization requirements are based upon contractual agreements between Randolph Community College and clinical agencies that provide clinical learning environments for students. Students must be in compliance with all health/immunization requirements to be eligible to participate in clinical opportunities at each facilities discretion. If a student does not meet and maintain health/immunization requirements for a specific agency, they are not eligible to participate in clinical in that facility. If the student cannot satisfactorily meet clinical requirements required of the associated program, the student will not be allowed to progress in the program and will be dismissed from the program.

| _____ | _____ | _____ |
|---|---|---|
| Student Name (Print) | Student Signature | Date |

**FORM A:**
**Personal Information—To Be Completed By Student** (Please print in black ink)

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN LAST 4 DIGITS SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo/day/yr)_____ GENDER ☐ M ☐ F MARITAL STATUS __S __M __ OTHER

EMAIL_____

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) – if no insurance, please write in N/A.

NAME OF POLICY HOLDER EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP (Should be Next of Kin)

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

Is it Ok to contact above person in the event of an emergency? YES _____ NO _____

Please list any medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

☐ Not currently taking any medication, prescribed or over the counter.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH(MO/DA/YR)

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on 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.

| **Adverse Reactions to:** | Yes | No | Explanation |
|---|---|---|---|
| Penicillin | | | |
| Sulfa | | | |
| Other antibiotics (name) | | | |
| Aspirin | | | |
| Codeine<br>Other pain relievers | | | |
| Other drugs, medicines, chemicals (specify) | | | |
| Insect bites | | | |
| Food allergies (name) | | | |

| | Yes | No | Explanation |
|---|---|---|---|
| Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe) | | | |
| Have you ever been a patient in any type of hospital? (Specify when, where, and why) | | | |
| Has your academic career been interrupted due to physical or emotional problems? (Please explain) | | | |
| Is there loss or seriously impaired function of any paired organs? (Please describe) | | | |
| Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe) | | | |
| Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details) | | | |

**FORM B:**
**Medical Form Review Attestation To Be Completed By The Student**

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH(MO/DA/YR)

**STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):**

(A) I have personally supplied (reviewed) 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 (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

**Signature of Student** **Date**

**Signature of Parent/Guardian, if student under age 18** **Date**

## FORM C:
## GUIDELINES FOR COMPLETING IMMUNIZATION RECORD AND TB SCREENING

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH(MO/DA/YR)

**IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit. Please review information noted in each section prior to entering information in sections A, B, and C.**

**All written information must be supported by documents (NCIR Registry, Titer Result from Laboratory Company, Employee Health Record, Pediatrician Office, etc.).**

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (Be certain that your name, date of birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. **Keep a copy for your records.**)

- High School/Previous College/University Records – These may contain some, but not all of your immunization information. Contact Student Services for help if needed. **Your immunization records do not transfer automatically. You must request a copy.**
- Personal Shot Records – Must be verified by a doctor's signature or by a clinic or health department stamp, including a printout from any Immunizations Registry.
- Military Records or WHO (World Health Organization Documents)
- Employee Health records are not sufficient, unless you received the required immunization from the facility and it is appropriately documented on the submitted document.

| **Item to Complete:** | **How to Complete It:** | Completed and Documented: |
|---|---|---|
| MMR | 2 vaccines or positive titer* | □ |
| Varicella (Chicken Pox) | 2 vaccines or positive titer* (history of the disease is **NOT** sufficient proof of immunity) | □ |
| Hepatitis B | 3 vaccines or positive titer*, or 2 dose series of Hep-B | □ |
| TB Skin Test ** | Complete:<br>1) the Baseline Individual TB Risk Assessment Form (https://www.cdc.gov/tb/topic/infectioncontrol/pdf/healthCareSettings-assessment.pdf)<br><br>2) a two-step PPD (2nd PPD administered 1-3 weeks after 1st PPD is read) within the last 12 months OR QuantiFERON®–TB Gold In-Tube test (QFT-GIT) or T-SPOT®.TB test (T-Spot) | □ |
| Tdap | Within 10 years (TD is **NOT** acceptable; must include pertussis) | □ |
| Flu Shot | Given only during flu season; nothing to upload until flu vaccine for most current flu season | □ |
| Covid | 1 vaccine or 2 vaccine based on manufacturer | □ |

*If a titer is submitted, a laboratory report must be attached. The healthcare provider should document positive or negative immunity.

**If a student has had a positive TB skin test in the past, such as due to TB exposure/infection or receiving the BCG vaccine, a chest x-ray will be required along with the Baseline Individual TB Risk Assessment and TB symptom evaluation. (Note: If a PPD is positive, chest X-ray should be negative for TB disease; X-ray should be no older than 1 year and individual asymptomatic for TB).

## FORM C: IMMUNIZATION RECORD AND TB SCREENING, To Be Completed By Health Care Provider

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH(MO/DA/YR)

| | Documentation of Compliance |
|---|---|
| **TUBERCULOSIS**<br><br>**All Students must complete one of the following screening tests**<br><br>▪ Screening with a 2-Step TST within 12 months of starting the program, must be administered 1-3 weeks apart with one 60 days within start of program.<br><br>▪ 2 consecutive annual tests administered 10 to 12 months apart, with the most recent administered within the past 12 months.<br><br>▪ QuantiFERON Gold blood test (lab report required) within the last 12 months.<br><br>If positive results, submit:<br>▪ A clear chest x-ray (report required) within the last year, AND proof of past positive testing.<br><br>▪ A Symptom Free TB questionnaire from the last 12 months (clinic site specific). | **2-Step Test**<br><br>1st TST: Date Read_____ Result _____ mm of induration<br>2nd TST: Date Read_____ Results _____ mm of induration<br><br>**OR**<br><br>2 Consecutive Tests<br><br>_____ Date _____ Date<br><br>**OR**<br><br>TB Blood Test Date (must attach lab report)<br>_____<br><br>**AND/OR**<br><br>Documentation by provider of chest x-ray attached for past positive PPD or blood test. |
| **Measles, Mumps and Rubella (MMR)**<br><br>Two MMR Vaccines<br><br>OR<br><br>Positive MMR Titer (must include all components, and lab report must be submitted. | MMR Vaccine #1 _____ Date<br>MMR Vaccine #2_____Date<br><br>**OR**<br><br>MMR Titer Lab attached (must include date drawn, numeric result and range of immunity.<br><br>**Please Circle Immunity Result:** Positive or Negative |
| **Varicella**<br><br>Two Varicella Vaccines<br><br>OR<br><br>Positive Varicella Titer (must include all components, and lab report must be submitted | Varicella Vaccine #1 _____ Date<br>Varicella Vaccine #2_____Date<br><br>**OR**<br><br>Varicella Titer Lab attached (must include date drawn, numeric result and range of immunity.<br><br>**Please Circle Immunity Result:** Positive or Negative |

**Healthcare Provider Clinic Stamp Required:**

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH(MO/DA/YR)

| | |
|---|---|
| **Hepatitis B**<br><br>Three Hepatitis B Vaccines<br><br>OR<br><br>Positive Varicella Titer (must include all components, and lab report must be submitted. | Hepatitis B Vaccine #1 _____ Date<br>Hepatitis B Vaccine #2_____Date<br>Hepatitis B Vaccine #3_____Date<br><br>**OR**<br><br>Hepatitis B Titer Lab attached (must include date drawn, numeric result and range of immunity.<br><br>**Please Circle Immunity Result:** Positive or Negative |
| **Tdap**<br><br>One Adult Tdap within the last 10 years | Tdap Vaccine #1_____Date |
| **COVID**<br><br>Must identify manufacturer, which identifies number of doses required | Manufacturer of vaccination _____<br><br>Vaccine #1 _____Date<br><br>**OR**<br><br>Vaccine #1 _____Date<br>Vaccine #2 _____Date |
| **Influenza (Seasonal)**<br><br>Required annually, in the fall of the year, generally around October 1. Due date to be announced annually and not required prior to admission. | |

**Signature of Physician/Physician Assistant/Nurse Practitioner** **Date**

**Print Name of Physician/Physician Assistant/Nurse Practitioner** **Area Code/Phone Number**

**Office Address** **City** **State** **Zip Code**

**Healthcare Provider Clinic Stamp Required:**

## FORM D:
## PHYSICAL EXAMINATION—To Be Completed By Health Care Provider (Please print in black ink)

A physical examination is required. It must be completed in black ink and signed by a health care provider.

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN DATE OF BIRTH (MO/DA/YR)

Height _____ Weight_____ TPR _____/_____/_____ BP _____/_____

| **ALL SECTIONS REQUIRED:** | **ALL SECTIONS REQUIRED:** |
|---|---|
| Vision: Corrected Right 20/ _____ Left 20/ _____<br>Uncorrected Right 20/ _____ Left 20/ _____<br>Color Vision _____ | Hearing: (gross) Right _____ Left _____<br>Whisper Right _____ Left _____ |

| Are there abnormalities? | Normal | Abnormal | DESCRIPTION (attach additional sheets if necessary) |
|---|---|---|---|
| 1. Head, Ears, Nose, Throat | | | |
| 2. Eyes | | | |
| 3. Respiratory | | | |
| 4. Cardiovascular | | | |
| 5. Gastrointestinal | | | |
| 6. Genitourinary | | | |
| 7. Musculoskeletal | | | |
| 8. Metabolic/Endocrine | | | |
| 9. Neuropsychiatric | | | |

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity (patient care activities) Unlimited _____ Limited _____
Explain _____

Based on my assessment of this student's physical and emotional health on _____ (Date), he/she appears to be able to participate in the activities of a health profession in a clinical setting and provide safe care to the public.

____ YES ____ NO, please explain _____

**Signature of Physician/Physician Assistant/Nurse Practitioner** **Date**

**Print Name of Physician/Physician Assistant/Nurse Practitioner** **Area Code/Phone Number**

**Office Address** **City** **State** **Zip Code**

## Healthcare Provider Clinic Stamp Required: