Student Medical Form for Programs that Require Health Forms

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

The Student Medical Form is a required component for students to participate in clinical experiences and/or in programs that require a provider to attest that the student is physically and emotionally capable of providing safe care to the public.

Once the Medical Form is completed and submitted to the program, **the student is responsible for notifying the program in writing 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 and/or in caring for the public). 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 potentially leading to dismissal from the program.

Each program will notify 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.

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 medical form should be completed no more than twelve (12) months before the student begins the clinical program and should be completed by a prescribing healthcare provider 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, physician's assistant or nurse practitioner complete the medical part of the form.
- The Immunization Record is extremely important. To avoid problems completing this information, read the Guidelines for Completing Immunization Record (see page 5). If you have any questions, please refer them to the Clinical Coordinator and/or Department Head for the program.

Instructions for Completing the Student Medical Form:

1. NOTE: It is helpful for you to retrieve your immunization history prior to contacting your provider to schedule an appointment, unless you received the vaccine from the scheduled healthcare provider.
2. Make an appointment with your primary care provider, or health care provider.
3. Form A: Personal Information, completed by student.
4. Form B: Immunization Record, completed by student and/or provider.
5. Form C: Medical Examination, completed by primary care provider, or health care provider.
6. Ensure that all entries on the form have been completed as indicated.

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 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 or clinical compliance 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

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mm/da/yr) _____/_____/_____ GENDER ☐Female ☐Male MARITAL STATUS___Single___Married

*NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

*NOTE: The individual listed as a point of contact will only be contacted in the event of an emergency and/or if you do not arrive to a clinical site/course experience without notifying a course instructor/clinical coordinator.

FORM B:
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.

All written information for immunizations must be supported by documents (i.e. NCIR Registry, Titer Result from Laboratory Company, Employee Health Record (ONLY if received by Employer), Pediatrician Office, etc.).

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (Be certain that your name and date of birth are on each record. The records must be in black ink and the dates of vaccine administration must include the month, day, and year.

- 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, 2 dose series of Hep-B (Adult series), OR positive titer*	□
TB Skin Test **	Complete: 1) QuantiFERON® TB Gold In-Tube test (QFT-GIT) or T-SPOT® TB test **(Radiography, Nursing, Medical Assiting)** 2) 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, or 2 consecutive annual tests administered 10 to 12 months apart, with the most recent administered within the past 12 months **(Medical Assisting)** 3) See Notes below regarding positive screening	□
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 vaccines based on manufacturer, for some programs.	□

*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 (Baseline Individual TB Risk Assessment Form (https://www.cdc.gov/tb/topic/infectioncontrol/pdf/health CareSettings-assessment.pdf)) 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).

***Student exemptions/declinations may be allowed per agency discretion. Program requirements may differ due to clinical agency requirements.

FORM B: IMMUNIZATION RECORD AND TB SCREENING, To Be Completed By Health Care Provider if being administered. If not, (Supporting Documents Required)

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

Measles, Mumps, Rubella (MMR)	2 doses of MMR	MMR Dose 1 ____/____/_____ MM DD YY	MMR Dose 2 ____/____/_____ MM DD YY		
	OR				
	Blood test titer confirming immunity (results of titer must be documented by provider)	Measles Titer ____/____/_____ MM DD YY Titer Result _____	Mumps Titer ____/____/_____ MM DD YY Titer Result _____	Rubella Titer ____/____/_____ MM DD YY Titer Result _____	
Hepatitis B	3 doses of Hepatitis B Vaccination, OR 2 doses as adult series	Hep B Dose 1 ____/____/_____ MM DD YY	Hep B Dose 2 ____/____/_____ MM DD YY	Hep B Dose 3 ____/____/_____ MM DD YY	
	OR				
	Blood test titer confirming immunity (results of titer must be documented by provider)	Hep B Titer ____/____/_____ MM DD YY Titer Result _____			
Varicella	2 doses of Varicella Vaccine	Varicella Dose 1 ____/____/_____ MM DD YY	Varicella Dose 2 ____/____/_____ MM DD YY		
	OR				
	Blood test titer confirming immunity (results of titer must be documented by provider)	Varicella Titer ____/____/_____ MM DD YY Titer Result _____			
Tdap (tetanus, diphtheria, and pertussis	Tdap Dose ____/____/_____ MM DD YY	Please specify vaccine type such as Boostrix or Adacel _____			

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FORM B: IMMUNIZATION RECORD AND TB SCREENING, To Be Completed By Health Care Provider (Supporting Documents documenting vaccination information is required)

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

Tuberculin Nursing and Radiography Requirement	Blood Test Titer-QuantiFERON Gold/TB Spot	Blood Test Titer ____ /____ /_____ MM DD YY Titer Result _____	If positive results, submit: ▪ A clear chest x-ray (report required) within the last year, AND proof of past positive testing.	
Tuberculin Medical Assisting Requirement	Blood Test Titer-QuantiFERON Gold/TB Spot **OR** ▪ 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. **OR** ▪ 2 consecutive annual tests administered 10 to 12 months apart, with the most recent administered within the past 12 months.	Blood Test Titer ____ /____ /_____ MM DD YY Titer Result _____	2-Step Test: 1st TST: Date Read_____ Result _____ mm of induration 2nd TST: Date Read_____ Results _____ mm of induration **OR** 2 Consecutive Annual Tests: 1st TST: Date Read_____ Result _____mm of induration 2nd TST: Date Read_____ Results _____ mm of induration	If positive results, submit: ▪ A clear chest x-ray (report required) within the last year, AND proof of past positive testing.
COVID (See Note on Page 5)	Dose 1 ____ /____ /_____ MM DD YY	Dose 2 ____ /____ /_____ MM DD YY	Additional Dose ____ /____ /_____ MM DD YY	Please specify vaccine type such as Pfizer or Moderna _____

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FORM C:
MEDICAL EXAMINATION—To Be Completed By Health Care Provider (Please print in black ink)

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

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

Allergies _____

Vision: Corrected Right 20/ _____ Left 20/ _____ Uncorrected Right 20/ _____ Left 20/ _____ Color Vision _____	Hearing: Right _____Left _____

	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
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 IF LIMITED _____

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/Clinic Name OR Clinic Stamp

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

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