Student Health Evaluation 2015

Name: ___________________________ Date: ___________________________

Last First Middle

Email: ___________________________ Student ID: ___________________________

Telephone: ___________________________ Age: ___________________________ Sex: ___________________________

Disclosure and Certification Statement:

I hereby grant permission for the release/disclosure of the information contained in this evaluation among appropriate college and clinical education staff whenever necessary for the evaluation of my fitness to enroll and/or remain in any of the healthcare programs at Long Beach City College. My signature below certifies that the information I have provided is true to the best of my knowledge. I understand that falsification of any of this information may constitute grounds for immediate dismissal from the program.

Signature: ___________________________ Date: ___________________________

Health History (check all that apply)

- Allergies
- Musculoskeletal/Back Injuries
- Cardiac Problems
- Neurological Problems
- Diabetes
- Seizure Disorder
- Hernia
- Cigarette Smoker
- Hypertension
- Substance Abuse
- Visual/Hearing
- Alcohol
- Respiratory
- Illegal Drugs
- Other
- Tuberculosis

Please explain any area(s) that you have checked: ____________________________________________________________

Please initial “YES” or “NO” below if you are able to perform the following physical maneuvers commonly required of healthcare students and professionals:

Stand and/or walk up to 8-12 hours per day

Lift a minimum of 35 pounds from floor level to waist level, and a minimum of 10 pounds from waist level to shoulder level

Carry a minimum of 20 pounds while walking a distance of 100 feet or more

Bend or flex the upper trunk forward up to 45 degrees and flex the lower torso into a squatting position

Rotate the upper trunk up to 30 degrees to the right and/or left from a neutral position while standing and/or sitting

Reach up to a height of 72” above floor level

Push and/or pull equipment or objects weighing up to 250 pounds

Please explain why you are unable to perform the above physical maneuvers: ____________________________________________________________
Essential Functions: All students are required, throughout the program, to meet the following essential functions for entry and continuation in the health programs.

Physical Demands
- Perform prolonged, extensive, or considerable standing/walking, lifting, positioning, pushing, and/or transferring patients
- Possess the ability to perform fine motor movements with hands and fingers
- Possess the ability for extremely heavy effort (lift/carry 50 lbs. or more)
- Perform considerable reaching, stooping, bending, kneeling, and crouching

Sensory Demands
- Color vision; ability to distinguish and identify colors (may be corrected with adaptive devices)
- Distance vision; ability to see clearly 20 feet or more
- Depth perception; ability to judge distance and space relationships
- Near vision; ability to see clearly 20 inches or less
- Hearing; ability to recognize a full range of tones

Working Environments
- Exposed to infectious and contagious disease, without prior notification
- Exposed to the risk of blood borne diseases
- Exposed to hazardous agents, body fluids and wastes
- Exposed to odorous chemicals and specimens
- Subject to hazards of flammable, explosive gases
- Subject to burns and cuts
- Contact with patients having different religious, culture, ethnicity, race, sexual orientation, psychological and physical disabilities, and under a wide variety of circumstances
- Handle emergency or crisis
- Subject to many interruptions
- Requires judgement/action in life/death situations
- Exposed to products containing latex

English Language Skills
Students must be able to communicate effectively, both verbally and written, with clients, colleagues and instructors to complete classes successfully and to ensure safety for themselves and for others.

Note
- Prior admission to a healthcare program, students demonstrate physical health as determined by a health history and physical examination.
- Entry and continuation in a healthcare program requires the student to submit a history and physical examination, and meet required immunizations, titers, TB clearance (PPD/Chest X-ray), and any other testing required by college, program, and clinical partner contractual requirements, including drug testing and background check.
- A current Healthcare Provider CPR card, renewed annually while enrolled.
- The college does not provide transportation to and/or from required clinical facility rotations.
- Entry and continuation in a healthcare program requires that students must earn a minimum grade of “C” in all program-related and other required courses.
Tuberculosis Screening: Tuberculin skin test (initial 2-step) and negative tuberculin skin test within 12 months. One to three weeks should elapse before the second tuberculin skin test.

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<thead>
<tr>
<th>#1 Date:</th>
<th>Results:</th>
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<tbody>
<tr>
<td>#2 Date:</td>
<td>Results:</td>
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</table>

If PPD results are positive or you have received a positive PPD in the past:

Chest x-ray results within the past six months

| CXR: | Results: |

Varicella Immunity: Must show a positive titer

| Varicella titer: | Date: | Results (numerical lab value): |

If Varicella titer is negative, two doses of varicella vaccine are required and a repeat positive titer.

| #1 Date: | #2 Date: | Repeat Titer: Date: |

Hepatitis B Immunity: Must show a positive titer

| Hepatitis B titer: | Date: | Results (numerical lab value): |

If titer is negative, Hep-B series must be initiated. After the 3rd injection, a follow-up positive titer is needed.

| #1 Date: | #2 Date: | #3 Date: |
| Repeat Hepatitis B Titer: Date: | Results: |

MMR Immunity: Must show positive titer for all three (3) diseases

| Rubella Titer: Date: | Positive: | Negative: |
| Rubeola Titer: Date: | Positive: | Negative: |
| Mumps Titer: Date: | Positive: | Negative: |

If negative titer, MMR immunization booster is required. Date: 

A follow-up titer is required after immunization. Repeat titer: |

| Tdap: Date: |

Annual Influenza

| Date: |
## Student Name: ____________________________  Date of Birth ____________________________

FOR CLINICIAN USE ONLY – STUDENTS DO NOT COMPLETE THIS PAGE

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<tr>
<th>EXAMINATION</th>
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<th>ABNORMAL</th>
<th>IF ABNORMAL, PLEASE NOTE DETAILS</th>
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<td>Allergy to Latex?</td>
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<td>Other Allergies</td>
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<td>Genito-Urinary &amp; Hernia</td>
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<td>Musculoskeletal</td>
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| Illnesses                    |        |          |                                  |
| Injuries                     |        |          |                                  |
| Restrictions on Activity     |        |          |                                  |
| Medications                  |        |          |                                  |
| Disabilities                 |        |          |                                  |

Temp  ________  Pulse  ________  Resp  ________  BP  ________

Name of Healthcare Provider: ____________________________________________
Address: ________________________________________________________________
Telephone: ______________________________________________________________

__________________________  ____________________________
Signature of Healthcare Provider  Date