LONG BEACH CITY COLLEGE

School of Health, Kinesiology, Science and Mathematics
Nursing and Allied Health Department

STUDENT HEALTH EVALUATION

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 (including Latex)
- Cardiac Problems
- Diabetes
- Hernia
- Hypertension
- Visual/Hearing
- Respiratory
- Other
- Musculoskeletal/Back Injuries
- Neurological Problems
- Seizure Disorder
- Cigarette Smoker
- Substance Abuse
- Alcohol
- Illegal Drugs
- 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:

	YES	NO
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: ______________________________

Student Name: ______________________________ **Date of Birth** ____________________

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Attach a copy of immunizations records and laboratory tests to document the following

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.*

#1 Date: ______________________ Results: ______________________

#2 Date: ______________________ Results: ______________________

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: **Date:** ____________________ **Results:** ______________

Tdap

Date: _____________________

Annual Influenza

Date: _____________________

Student Name: ______________________________ **Date of Birth** ____________________

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EXAMINATION	NORMAL	ABNORMAL	IF ABNORMAL, PLEASE NOTE DETAILS
General Appearance			
Vision			
Hearing			
Allergy to Latex?			
Other Allergies			
Skin, Nails & Hair			
HEENT			
Neck			
Lungs			
Heart			
Abdomen			
Back			
Genito-Urinary & Hernia			
Musculoskeletal			

Illnesses	
Injuries	
Restrictions on Activity	
Medications	
Disabilities	

Temp ____________ **Pulse** ____________ **Resp** ____________ **BP** ____________

Name of Healthcare Provider: ______________________________

Address: ______________________________

Telephone: ______________________________

______________________________ ____________________

Signature of Healthcare Provider **Date**