McDowell Technical Community College
54 College Drive
Marion, NC 28752

Print Full Name: ____ Date *turned* in: __________

ID# (or SS#) _______________________

2022-2023 Student Medical Form for (Please check one)

Health Information Technology _______
Practical Nursing _______
Paramedic (Con Ed) _______
Phlebotomy (Con Ed)
Emergency Medical Science
(EMS Paramedic Curriculum) _______

DO NOT SEPARATE THESE FORMS

It is very important that you read and follow all directions in this packet.
Make sure all information is complete before turning in your packet.
Partial packets *will not* be accepted.
Thank you.

Copies of records may be attached, but information MUST be filled out and a signature is required by the physician or designee on the forms

PLEASE MAKE A COPY OF THESE FORMS FOR YOUR RECORDS. FORMS ARE DESTROYED ONCE A STUDENT GRADUATES OR LEAVES THE PROGRAM

McDowell Technical Community College
Health Science Department

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT: The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

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 remain together. The records must be in black ink and the date of vaccine administration must include the month, day, and year. **KEEP A COPY FOR YOUR RECORDS**.)

- High School Transcripts – These **may** contain some, but not all of your immunization information. Contact your high school for these records if needed for immunization purposes.
- Personal Shot Records – Must be verified by a doctor's stamp or signature or by a clinic or health department stamp
- Local Health Department
- Military Records or WHO (World Health Organization Documents)
- Previous College or University – **Your immunization records do not transfer automatically. You must request a copy**

Our clinical agencies base their requirements on the Center for Disease Control's (CDC) Recommendations for Healthcare Providers (HCP). Here are those requirements:

Required Immunizations	
Tdap (Tetanus, Diphtheria, Pertussis)	Get a one-time dose of Tdap as soon as possible if you have not received Tdap previously (regardless of when previous dose of Tdap was received). Get Td boosters every 10 years thereafter. Pregnant HCPs need to get a dose of Tdap during each pregnancy.
MMR (Measles, Mumps, & Rubella)	If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to measles, mumps, and rubella (i.e., no serologic evidence of immunity or prior vaccination, get 2 does of MMR, 4 weeks apart. If you were born before 1957, you may be immune, but healthcare agencies require either immunity based on a blood draw or 2 MMRs.
Varicella (Chickenpox)	If you have no had chickenpox (varicella), if you haven't had a varicella vaccine, or if you don't have an up-to-date blood test that shows you are immune to varicella (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of varicella vaccine, 4 weeks apart.
Tb Skin Test 2-step	Please obtain Tb screen test, screening, or chest X-ray after **August 1, 2022.**
Flu (Influenza)	Get 1 dose of influenza vaccine annually. **(September 1, 2022 - October 1, 2022)**
Recommended Immunizations	
Meningococcal	Those who are routinely exposed to isolates of *N. meningitides* should get one dose.
Hepatits B	If you don't have documented evidence of a complete hepB vaccine series, or if you don't have an up-to-date blood test that shows you are immune to hepatitis B (i.e., no serologic evidence of immunity or prior vaccination) then you should • Get the 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2). ***Highly recommended. See page 5 for required signature.**

To learn more about these diseases and the benefits and potential risks associated with the vaccines, read the Vaccine Information Statements (VIS) at http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html

- Centers for Disease Control and Prevention
  1600 Clifton Rd
  Atlanta, GA 30333
- Contact CDC-INFO 800-CDC-INFO
  (800-232-4636) TTY: (888) 232-6348

McDowell Technical Community College
Health Science Department

IMMUNIZATION RECORD –

(Please print in black ink). To be completed and signed by a physician or clinic. A complete immunization record from a physician or clinic may be attached to this form. Students may be denied clinical privileges for refusing required immunizations, which may result in dismissal from the program.

Last Name	First Name	Middle Initial	Date of Birth (mo/day/year)	ID or SS#

REQUIRED IMMUNIZATIONS				
	mo/day/year	mo/day/year	mo/day/year	mo/day/year
DTP or Td	(#1)	(#2)	(#3)	(#4)
Td booster				
T-dap				
Polio				
MMR (after first birthday)				
MR (after first birthday)				
Measles (after first birthday)			Disease Date/PCP Signature	Titer Date, Result, Documentation
Mumps			(Disease Date NOT Accepted)	Titer Date, Result, Documentation
Rubella			(Disease Date NOT Accepted)	Titer Date, Result, Documentation
Varicella (chicken pox) series of two doses or immunity by positive blood titer		(#1)	(#2) (Disease Date NOT Accepted)	Titer Date, Result, Documentation
Tuberculin (PPD) Test within 12 months or risk **Please obtain after August 1, 2022** -----------OR------------- Chest X-ray, if the PPD is positive (or documentation of screening *annually* on Department of Health and Human Services "Result of TB Screening")		Date read:	(1)	(2)
		mm induration:		
		Date:		
		Results:		
Flu Vaccine – Current Vaccine due **between September 1 -October 1, 2022 (Must have before October 1, 2022)** Clinical facilities may require students to wear a mask during clinical rotations or refuse the student a clinical experience if the student has not had the flu vaccine.		**Between September 1 - October 1, 2022** mo/day/year location:	Medical Waiver if Applicable: - Documentation Attached	

RECOMMENDED IMMUNIZATIONS				
The following immunizations are recommended for all students.				
Meningococcal	Received the meningococcal vaccine? **NO** _____ **YES** _____			
If **Yes**, please indicate date(s) vaccine was received (mo/day/year):				
	mo/day/year	mo/day/year	mo/day/year	
Hepatitis B series only* -----------OR------------- Hepatitis A/B combination series				Titer Date, Result, Documentation

***Highly recommended. See page 5 for required signature.**

Signature or Clinic Stamp REQUIRED:

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

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

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PHYSICAL EXAMINIATION BY MEDICAL PRACTITIONER

Please print in black ink – **Complete ALL of the following:**

____

Last Name | First Name | Middle Name | Date of Birth (mo/day/year) | ID or SS#

Height __________ **Weight** __________ **TPR** _________ / _________ / _________ **BP** _________ / _________

VISION:			**URINALYSIS:**
Corrected	Right 20/ __________	Left 20/ __________	Sugar: _______________ Albumin_______________
Uncorrected	Right 20/ __________	Left 20/ __________	Micro: _______________
Color Vision	_____________________________________		
HEARING:			**COMPLETE BLOOD COUNT:**
(gross)	Right ____________	Left ____________	Hgb or Hct ___________________
15 ft.	Right ____________	Left ____________	

A. Is there loss or seriously impaired function of any single or paired organs? Yes _______ No _______
Explain: ____
____
____

B. Is student under treatment for any medical or emotional condition? Yes _______ No _______
Explain treatment/medication: ____
____
____

C. Recommendation for physical activity (during patient care activities) Unlimited______ Limited ______
Describe limitation: ____
____

Based on my assessment of this student's physical and emotional health on ________________________, he/she
(date)
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 _______
If 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**

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TO BE COMPLETED BY STUDENT (Please print in black ink)

____
Last Name (print) First Name Middle/Maiden Name SS#* email address

____
Permanent Mailing Address City State Zip Area Code/Phone Number

Date of Birth (mo/day/yr) ________________________ Gender _____ M _____ F Marital Status _____ S _____ M _____ Other

Insurance Information:

____
Hospital/Health Insurance (Name and Address of Company) Area Code/Telephone Number

____
Name of Policy Holder Social Security Number Employer

____ Is this an HMO/PPO/Managed Care Plan _____ Yes _____ No
Policy or Certificate Number Group Number

Emergency Contact Information:

____
Name of Person to Contact in Case of Emergency Relationship

____
Address City State Zip Area Code/Telephone Number

HEPATITIS B

ONLY COMPLETE PART A OR PART B, NOT BOTH

PART A – Compliance

I, ____
(Last Name) (First Name) (Middle Name) (Maiden)
in compliance with OSHA guidelines I have received or agree to receive the Hepatitis B vaccine series. I have read the *Important Information About Hepatitis B and Hepatitis B Vaccine* sheet and understand that I am at risk of contracting Hepatitis B due to my job or clinical related activities. I have been given the opportunity to ask questions and understand the risk factors involved.

______________________________ ___ ____
(Student Signature) (Witness Signature) (Printed Name) (Date)

* *

Part B – Waiver

I, ____
(Last Name) (First Name) (Middle Name) (Maiden)
have read the *Important Information About Hepatitis B and Hepatitis B Vaccine* sheet and understand that I am at risk of contracting Hepatitis B due to my job or clinical related activities. I have participated in a formal education program and I have been given the opportunity to ask questions and understand the risk factors involved. I am refusing to receive the Hepatitis B vaccine series.

______________________________ ___ ____
(Student Signature) (Witness Signature) (Printed Name) (Date)

* Provision of Social Security is requested solely for administrative purposes and record-keeping accuracy. It is requested to provide a personal identifier for the internal records of this institution.

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REPORT OF MEDICAL HISTORY *(Please print in BLACK ink – to be completed by student)*

STUDENT DEMOGRAPHIC INFORMATION

____
LAST NAME (PRINT) FIRST NAME MIDDLE/MAIDEN NAME DATE OF BIRTH (MO/DAY/YR) SCHOOL STUDENT ID#

____
PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

____
GENDER (MALE/FEMALE) MARITAL STATUS (SINGLE/MARRIED/DIVORCED) SCHOOL EMAIL ADDRESS

EMERGENCY CONTACT INFORMATION

____
NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

____
ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

HEALTH INSURANCE INFORMATION

____
HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

____
NAME OF SUBSCRIBER SUBSCRIBER ID GROUP NUMBER EMPLOYER

FAMILY HEALTH HISTORY *(Please place a check mark for yes or no and indicate the relationship to the family member)*

	Yes	No	Relationship			Yes	No	Relationship
High blood pressure					Glaucoma			
Stroke					Seizure disorder			
Heart attack before age 65					Cancer (type)			
Blood or clotting disorder					Substance Abuse Disorder			
High Cholesterol/Triglycerides					Psychiatric Illness			
Diabetes					Suicide			

PERSONAL HEALTH HISTORY *(Please indicate if YOU have a history of the following)*

	Alcohol Abuse			Depression			Mental Illness
	Anemia			Diabetes			Migraines
	Anesthetic Complication			Growth/Development Disorder			Osteoporosis
	Anxiety Disorder			Hearing Impairment			Prostate Cancer
	Arthritis			Heart Attack			Rectal Cancer
	Asthma			Heart Disease			Reflux/GERD
	Autoimmune Problems			Chest Pain/Angina			Seizures/Convulsions
	Birth Defects			Hepatitis A			Severe Allergy
	Bladder Problems			Hepatitis B			Sexually Transmitted Disease
	Bleeding Disease			Hepatitis C			Skin Cancer
	Blood Clots			High Blood Pressure			Stroke/CVA of the Brain
	Blood Transfusion(s)			High Cholesterol			Suicide Attempt
	Bowel Disease (IBS/IBD)			HIV			Thyroid Problems
	Breast Cancer			Hives			Ulcer
	Cervical Cancer			Kidney Disease			Visual Impairment
	Colon Cancer			Liver Cancer			Other Disease, Cancer or Significant Illness
	Crohn's Disease			Lung/Respiratory Disease			

List other past medical problems/surgeries/hospitalizations: ____
____
____
____

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Prescribed Drugs/OTC/Vitamins/ETC. (List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers)

Drug ______________________ Dose/Frequency__________ Drug _____________________ Dose/Frequency _________
Drug ______________________ Dose/Frequency__________ Drug _____________________ Dose/Frequency _________
Drug ______________________ Dose/Frequency__________ Drug _____________________ Dose/Frequency _________
Drug ______________________ Dose/Frequency__________ Drug _____________________ Dose/Frequency _________

□ List additional drugs on back of questionnaire

□ I take no medications, vitamins, or any other over-the-counter preparations

Drug Allergies/Allergic Reaction

Name ____ Reaction You Had ______________________________________
Name ____ Reaction You Had ______________________________________

□ I have no known **drug** allergies

Question	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 healthcare 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)			

IMPORTANT INFORMATION…PLEASE READ

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 (if under 18, my child's) medical record to a physician, hospital, or other medical professional involved in providing me (if under 18, my child) with emergency medical treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (if under 18, my child) that may be advised or recommended by the medical professional providing emergency medical treatment or medical care.

(C) I accept personal responsibility for settling any accounts owed for my care with the facility providing the care and acknowledge the institution is not responsible for my care or any fees owed to an outside agency.

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