MT. SAN ANTONIO COLLEGE
Technology and Health Division
1100 North Grand Avenue • Walnut, CA 91789
909.274.5145 • FAX 909.274.2027

PROGRAM ENROLLED IN: _____

2014/15 STUDENT MEDICAL HISTORY/PHYSICAL EXAMINATION

To the student: Complete this page and the medical history section.

- Your medical provider must complete the physical examination portion no more than three months prior to entering the clinical phase of your program.
- Return all completed documents to the Fire Technology Office, Building 28B, Room 214.

Your Name: _____ Mt. SAC ID# _____
First Middle Last

Your Phone: _____ _____
Home Cell/Message

In Case of Emergency, please contact:

_____ _____
Name Relationship to you

_____ _____
Day Phone Evening Phone

CONSENT FOR RELEASE OF HEALTH INFORMATION

I hereby consent to the communication of my health record from the college to those cooperating agencies as they may request.

SIGNATURE_____ DATE_____

MEDICAL HISTORY

Have you ever had:

1. a cough or shortness of breath on moderate exertion? No___Yes___ Explain: _____
2. hay Fever, Asthma, Eczema or other allergic reactions including medications? No___Yes___ Explain: _____
3. an operation? No___Yes___ Explain: _____
4. an injury that would limit body movement or affect your ability to lift or move patients? No___Yes___ Explain: _____
5. any skin problems that result in open sores, cracks or irritation of your skin? No___Yes___ Explain: _____
6. Do you routinely or currently take any drugs or medications? No___Yes___ Explain: _____
7. Tuberculosis? No___Yes___ Type: _____
8. Heart disease? No___Yes___ Explain: _____

Name _____ ID# _____
First Middle Last

ALL TESTS MUST BE DATED WITHIN ONE YEAR EXCLUDING IMMUNIZATIONS. SIGNATURES AND LICENSURE REQUIRED, INCOMPLETE FORMS WILL BE DENIED

Medical Office Stamp Required	*Immunization or Lab Test*
	TUBERCULOSIS SCREENING (2 Step Required Within 3 Weeks) Date Administered: _____ Date Read: _____ Results: _____ mm ☐ Negative ☐ Positive Certified by: _____ MD, RN, RNP, PA Date Administered: _____ Date Read: _____ Results: _____ mm ☐ Negative ☐ Positive Certified by: _____ MD, RN, RNP, PA
	CHEST X-RAY (With Proof of Positive Skin Test) Date: _____ ☐ Negative ☐ Positive Certified by: _____ MD, RN, RNP, PA
	BLOOD TESTS (TITERS) ***(If not immune, must get vaccine)*** Results: Mumps – ☐ Immune ☐ Not Immune Rubella – ☐ Immune ☐ Not Immune Rubeola – ☐ Immune ☐ Not Immune Varicella – ☐ Immune ☐ Not Immune Date Administered: _____ Certified by: _____ MD,RN,RNP,PA
	MEASLES/MUMPS/RUBELLA IMMUNIZATION (Required if not immune) Date Administered: _____ Certified by: _____ MD,RN,RNP,PA
	VARICELLA IMMUNIZATION (Required if not immune) Date Administered: _____ Certified by: _____ MD,RN,RNP,PA
	TETANUS/DIPHTHERIA IMMUNIZATION – "Td" (may be self-certified) **(Within 10 years)** Date Administered: _____ Certified by: _____ MD,RN,RNP,PA
	Tetanus/diphtheria/pertussis immunization (Tdap), (if has not had a booster since age 15; must provide documentation of booster if received after age 15). See disclaimer* Date Administered: _____ Certified by: _____ MD,RN,RNP,PA

Name _____ ID# _____
First Middle Last

	TDAP DISCLAIMER**:* *I understand that I may be at risk of acquiring Pertussis infection, or transmitting the infection to others. I have been given the opportunity to be vaccinated with the Pertussis vaccine.* ***I decline the Pertussis vaccination at this time. *I understand that by declining this vaccine, I continue to be at risk of acquiring Pertussis, a serious disease. I understand that it is recommended that I receive this vaccine as soon as possible.* Signature: _____ Date: _____
	POLIO VACCINE (may be self-certified) Date Administered: _____ Certified by: _____ MD,RN,RNP,PA

HEPATITIS B

YOU MUST COMPLETE THE VACCINATION SERIES, PROVIDE PROOF OF POSITIVE TITER, OR SIGN THE DISCLAIMER.

VACCINATION SERIES
Date of First Dose: _____
Date of Second: _____
Date of Third: _____

HBsAB TITER
Date: _____
Results: ☐ Immune ☐ Not Immune
If not immune, get vaccine series or sign disclaimer

Certified by: _____ *MD,RN,RNP,PA*

Medical Office Stamp:

***DISCLAIMER**:*
I understand that I may be exposed to blood or other potentially infectious materials during clinical assignments. I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine. ***I decline the Hepatitis B vaccination at this time.*** *I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. I understand that it is recommended to start this vaccine as soon as possible.*

Signature _____ Date _____

PHYSICAL EXAMINATION

CONDITION OF:

Eyes _____ *Ear* _____
Nose _____ *Skin* _____
Throat _____ *Thyroid* _____
Lungs _____ *Cardiac* _____
Blood pressure _____ *Pulse rate/rhythm* _____
Abdomen _____ *Handicaps* _____

Name _____ ID# _____
First Middle Last

LAB RESULTS: W.B.C. _____ Hgb _____ Hct _____

URINE: Sp. Gr. _____ Protein _____ Sugar _____

URINE DRUG/ALCOHOL TEST:
Date: _____ ☐ Passed ☐ Failed

Use of Self-Contained Breathing Apparatus (SCBA) Respirator

OSHA Respirator Medical Evaluation Questionnaire completed and reviewed _____

Recommendations

☐ I find this person able to participate in a health occupations program, which would include direct patient contact and use of the SCBA respirator.

☐ I **DO NOT** find this person able to participate in a health occupations program, which would include direct patient contact and use of the SCBA respirator due to:

a. Facial hair obstructs proper fit of the respirator.
b. Further information is needed for review:_____.
c. A temporary health problem, _____, is present and must be re-evaluated in ___ months.
d. A permanent health problem is present, _____
Recommendation:_____

Comments: _____

_____

Date _____ Print name _____ Signature _____ MD, RNP, PA

Facility _____

Medical Office Stamp: