

Do you have a sensitivity or allergy to latex? No _____ Yes _____ If yes, complete the "Latex Reaction Form" which can be accessed at www.csc.edu/docs/health/forms/LATEX.pdf.

List all allergies and sensitivities you have including medications, food, & environmental:

List all surgical operations you have had with the date:

List all current health conditions you have:

List any previous significant health problems you have had:

Do you have a history of chickenpox? _____ Please enter Month/Year _____

The information you are reporting to Columbus State Community College is used to provide immunization and health information required by the college's clinical affiliates, and to verify your ability to perform essential functions of the clinical tasks safely.

It is the policy of Columbus State Community College not to discriminate against any individual. This assurance of non-discrimination includes applicants for academic admission, and shall be applied regardless of race, color, gender, age, religion, ancestry, national origin, disability, or veteran status.

I certify that the health information I have given is accurate and complete. I understand that providing false information on this document is a serious offense which will result in disciplinary action. I understand that if my health, physical condition, or physical abilities change during my enrollment in a health-related program at Columbus State Community College I must report these changes to my program coordinator and to the Academic Health Records Office. I understand that immunization records and tuberculin testing results may be released to clinical sites prior to my clinical/practicum experiences. I understand that conditions which may affect my ability to perform essential functions of the clinical tasks or which may affect my ability to function with safety for myself and/or others might be discussed with my department chair or program coordinator.

Student Signature

Date

**COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORD**

Physical Examination: May be performed by Physician, Nurse Practitioner or Physician's Assistant

Name: _____ SS#: _____
Last First Middle

Allergies: _____

Medications: _____

Height: _____ Weight: _____ Pulse: _____ B/P: _____

EXAMINER: Indicate your findings after examination of each system

EENT: _____

NEURO: _____

CV: _____

RESP: _____

ENDOCRINE: _____

MUSC/SKEL: _____

- If this student has any reaction to latex, please complete the Examiner's portion of the "Latex Reactions Form" that the student will supply to you.
- If this student is subject to any health emergency, please provide special emergency instructions below.
- If there is additional significant information about this student which would relate to his or her safety for patients or for self in a clinical or laboratory situation, please provide information below.

Does the student report a history of varicella virus (chickenpox)? _____ Month/Year _____

Does student have any functional limitations or restrictions that would prevent him/her from working in a patient care area?	Yes	No
Vision, such as reading gauges or thermometers?		
Hearing, such as in a classroom or when using a stethoscope?		
Speech, such as in a classroom?		
Lifting up to 50 pounds?		
Ambulation/Standing for several hours?		
Ability to handle stress?		
Sensorimotor (fine and gross)?		

Does the student have any limitations or restrictions? If yes, please provide specific facts regarding student's requirements _____

Tuberculosis Testing

Two-Step Mantoux (intradermal) is required. This involves two Tb Mantoux tests at least 7 days apart and within the last year. Two or three days after each Tb test is given it must be read by the physician, nurse, or physician's assistant. Tb tine tests are not acceptable per state regulations. Two Mantoux tests within the past year can be substituted per state regulations. If the student recently received an MMR or varicella vaccine, the tuberculosis test must be postponed for at least four to six weeks.

Tb#1

Date given: _____

Date read: _____

Result: _____ mm.

Read by: _____

Tb#2 At least 7 days after the first Tb test:

Date given: _____

Date read : _____

Result: _____ mm

Read by: _____

If this test or a previous test is positive: Submit documentation of positive PPD and a negative chest x-ray post-conversion.

Examiner's Signature: _____

Print Examiner's Name: _____

Address: _____

Phone: _____

Date: _____

Submit completed health record to: Columbus State Community College, Academic Health Records Office, Room 134A Union Hall, 550 East Spring Street, Columbus OH 43215, or fax to 614-287-5386, including current name and social security number on all faxed pages. QUESTIONS?? Call 614-287-2450 or email to pbaker@csc.edu - lwashi01@csc.edu

**COLUMBUS STATE COMMUNITY COLLEGE
SUPPLEMENTARY IMMUNIZATION RECORD**

For Students in NUCLEAR MEDICINE AND RADIOGRAPHIC TECHNOLOGY ONLY.

NAME _____ SS# _____

PROGRAM _____ BEGIN QTR: _____

**TO BE COMPLETED BY THE PHYSICIAN, NURSE PRACTITIONER, OR
PHYSICIAN ASSISTANT ONLY**

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED:

1. Hepatitis B: Proof of immunity must consist of:

Dates of hepatitis B vaccination: #1 _____, #2 _____,
#3 _____ (Minimum one injection before submitting health record and others
completed on schedule; or on schedule at present if series was begun at an earlier date)

OR

Date and results of hepatitis B **surface antibody** _____ NOTE:

If the surface antibody is negative, the student must receive the immunization series.

OR

If the student is pregnant and has not had the immunization series, date and results of
hepatitis B **surface antigen** _____.

NOTE: The student must receive the immunization series after the pregnancy unless
already immune.

2. Measles/Rubeola: Proof of immunity must consist of:

Date of first immunization _____ Date of second _____

OR

Date and results of rubeola **IGG** titer _____

If titer is negative, the student must receive the immunization at this time unless the student
is pregnant.

OR

If the student is pregnant and has a negative titer she must receive the rubeola immunization
after the pregnancy and provide documentation to the Health Records Office.

**DO NOT RECEIVE THE MEASLES/RUBEOLA OR MMR IMMUNIZATIONS
WHILE YOU ARE COMPLETING THE TWO-STEP TUBERCULOSIS TEST.** The
measles component invalidates the tuberculosis test, so you would have to repeat the
tuberculosis testing which may delay your ability to register into your program.

3. **German Measles/Rubella:** Proof of immunity must consist of:

Date of immunization _____

OR

Date and results of rubella **IGG** titer _____

If titer is negative, the student must receive the immunization at this time unless the student is pregnant.

OR

If the student is pregnant and has a negative titer she must receive the rubella immunization after the pregnancy and provide documentation to the Health Records Office.

DO NOT RECEIVE THE MMR IMMUNIZATION WHILE YOU ARE COMPLETING THE TWO-STEP TUBERCULOSIS TEST. The measles component invalidates the tuberculosis test, so you would have to repeat the tuberculosis test and this could prevent you from entering your program on schedule.

4. **Mumps:** Proof of immunity should consist of:

Date of immunization _____

OR

Date and results of mumps **IGG** titer _____

5. **Chickenpox/Varicella:** Proof of immunity must consist of:

Date of first immunization _____ Date of second _____

Two injections are required for adults, given four to eight weeks apart. Minimum one injection before submitting health record with second completed on schedule; or both on schedule at present if series was begun at an earlier date.

OR

Date of physician-documented chickenpox/varicella zoster illness _____

OR

Date and results of varicella **IGG** titer _____

OR

If the student is pregnant and has no history of varicella disease and a negative titer she should consider receiving the immunization series after the pregnancy.

6. **Tetanus:** Proof of immunity should consist of:

Date of immunization within past ten years _____

Signature: _____

Printed Name and Title: _____

Organization: _____

Phone: _____

Date: _____

Health Care Related Programs Risks and Pregnancy Guidelines

Students in each of the college's health-related programs, where laboratory or clinical practice is part of the course, will be working with other students and patients in various states of health/illness. As stated in the contracts with our clinical partners, no patient is discriminated against in the provision of health care. Therefore, students may be exposed to various diseases, micro-organisms and pathogens. All students learn 'Standard Precautions' and are required to practice these in labs and clinical facilities in order to minimize risk. However, it is important to understand there is always risk.

Examples of potential risks to students in clinical/laboratory placements include:

- Ionizing radiation may cause damage to a student or developing fetus, when the student does not use required shielding.
- Students may be exposed to communicable diseases. Students are required to have immunizations and health exams prior to beginning some laboratory and all clinical courses.
- Risk of falling, especially on wet surfaces.
- Risk of injuries related to lifting heavy objects or moving patients
- Risk of needle-stick or instrument-related injuries
- Risk of bloodborne pathogen exposure
- Risk of infections or injuries incurred through working with animals.

Statement Regarding Pregnancy:

Student disclosure of her pregnancy status to program personnel is strictly voluntary. While the college does not require that a pregnant student disclose her pregnancy, the college encourages any student who is pregnant or may become pregnant to discuss with her advisor any potential risks and limitations.

Pregnancy does not preclude a student from remaining in a health-related program. Students disclosing a pregnancy are encouraged to have their health-care practitioner document any restrictions that may assist the college in providing reasonable accommodations when required.

Should the student's health-care provider indicate that there are restrictions, once notified, the college is required to abide by the restrictions. If a student is placed on restrictions by her health-care provider and these restrictions are significant enough to compromise the student's ability to continue in a laboratory course or clinical placement, the student may be required to withdraw from the course and re-enter the program at a later date, following delivery. If a health-care provider indicates that there are no restrictions, the student may continue in her laboratory or clinical course without any changes.

Statement Regarding Infectious Diseases:

Students may be exposed to many types of communicable diseases in the clinical environment. These diseases are not limited to but may include: Hepatitis (A, B, C or D), HIV/AIDS, TB, measles, mumps, rubella, rubeola, etc.

ALL students are required to have appropriate immunizations after they are admitted to their program of study (specific information is given to all admitted students). Requirements vary from program to program, depending on the clinical environments. Additionally, although all precautions are taken to minimize exposure and risk, there is always a slight possibility that precautions may fail or that a student may accidentally expose him/herself. All students entering a health-related program of study must be aware of this slight, but real, potential. While students in some programs are required to maintain personal health insurance, ALL students are encouraged to do so.

Health Care Related Programs Pregnancy Risk Form

Student Section:

I have read the Health Care Related Programs Risks and Pregnancy Guidelines and understand the potential risks that may exist to me and my unborn child should I decide to continue in health program laboratory and clinical placements for the remainder of my pregnancy.

Student signature: _____

Date: _____

Health Care Provider Section:

I have read the Health Care Related Programs Risks and Pregnancy Guidelines and am identifying the following laboratory/clinical practice restrictions that my patient is to adhere to for the remainder of her pregnancy:

Student Name _____

Laboratory/Clinical Restrictions:

EDC _____

Physician Name: _____

Date: _____

