

Do you have a sensitivity or allergy to latex? No_____ Yes_____

If yes you will need to complete the “Latex Reaction Form” which can be accessed from the college’s web site at http://csc.c.edu/services/hr_pdf/LatexReactionForm.pdf . Print the form, complete your portion, and then give the form to your physician to complete his or her portion. Your completed Latex Reaction Form must be submitted with the rest of your health record forms.

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:

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 sex, race, color, religion, national origin, ancestry, age, disability, genetic information (GINA), military status, sexual orientation, and gender identity and expression.

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 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

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 _____

Hepatitis B Immunization

Please document date of three injections administered or photocopy of positive surface antibody within the past three years; you must receive the first and second injection before you can register for your MedLab courses. The second one is given one month later and the third is given five months after the second immunization.

Date given: _____ Date given: _____ Date given: _____

Signature _____ Signature _____ Signature _____

Date of hepatitis surface antibody _____ Results _____

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

Examiner's Signature: _____

Print Examiner's Name: _____

Address: _____

Phone: _____ Date: _____

Submit completed health record to: Columbus State Community College, Health Records Office, Union Hall Room 132, 550 East Spring Street, Columbus OH 43215; or fax to 614-287-5386, including current name and Cougar ID on all faxed pages. You may also email your Health Record to healthrecords@csc.edu **Emails will only be accepted from your student email account (@student.csc.edu) QUESTIONS?? Call 614-287-2450**