CALHOUN COMMUNITY COLLEGE
HEALTH SCIENCES DIVISION
PHYSICAL EXAM

To the Student: ***Complete Part I on the Physical Exam Only.***

I. Name:______________________________________ Calhoun ID:__________________

Program of Study: CLT ▢ DAT ▢ EMS ▢ NUR ▢ PTA ▢ SUR ▢

Date of Birth: __________________________ Age: ____________ Gender: __________

Allergies (Describe agent and reaction):____

Currently Pregnant: ___ Yes ___ No

Emergency Contact: Name: _______________________________ Phone: ______________

To the Physician: Please complete the following form based on clinical findings and knowledge of the student's past medical history.

II. Height: _____________ Weight: _____________

Vision: 20/_____ OS 20/_____ OD Corrected by: ___ Glasses ___ Contact lens

Temp: __________ Pulse: __________ Resp: ________ BP: ________ /_______

Physical Examination (Notes):

HEENT: ____

CVR: ____

ABD: ____

GU: ____

Please state any significant medical history or limitations for this student:

____

____

NOTICE: The Alabama Infected Health Care Worker Management Act mandates that any health care worker who performs invasive procedures and who is infected with human immunodeficiency virus (HIV) or hepatitis B virus shall notify the State Health Officer or his designee of the infection.

To The Physician: **Please record the answers to the questions below. Some questions require input from the student. Others will be obtained from the examination.**

YES	NO	
		Does the student have, at a minimum, vision in one eye corrected to 20/20?
		Does the student have visual ability to include color perception?
		Does the student have the ability to send and receive verbal messages?
		Does the student meet the "Essential Functions" of the program? ***See Last Page***

III. IMMUNIZATIONS AND LABORATORY TESTS

Instructions: Please note that the student has received the following immunizations and/or lab tests. Immunizations and lab test(s) required are:

Confirmed or administered

1. Tetanus/D within the past ten years
2. Varicella Vaccine – 2 vaccines (Chicken Pox), or Varicella Titer
3. MMR Vaccine prior to 1969, or Rubella Titer of 1:8 or above is sufficient in lieu of MMR
4. Two-step TB Skin Test or Chest X-Ray (if positive)
5. Hepatitis B Vaccination Series – proof of series completion **or** proof of immunity
   NOTE: *Students with incomplete series or choosing not to be vaccinated must sign the* ***Vaccination Waiver*** *printed on page 3.*
6. Influenza Vaccination required during influenza season or must ***sign waiver*** (Documentation Required)

To the Physician:

Mantoux Two-Step TB Skin Test *Please initial behind date* *See page 4 for details*	1st Step Date Given:_____ by: ____ 1st Step Date Read:_____ by:____ Results:______ 2nd Step Date Given:______ by: ____ 2nd Step Date Read:______ by:____ Results:______
Hepatitis B Vaccination *See page 4 for details*	1st Date_________ 2nd Date__________ 3rd Date ___________ Titer Date: _______________ Immunity:____ No Immunity: ____
MMR & Tetanus	MMR Vaccine Date: ____________ Tetanus Date: _____________ **or** Rubella Titer Date: ___________ Immunity: ____ No Immunity: ____
Varicella Vaccine 4-8 weeks apart	Immunization Dates: _______________, ____________________ **or** Titer Date: ____________ Immunity: _____ No Immunity: _____
Influenza Vaccine	Date of Vaccine: _____________________ Location Given: ______________________ or Sign Waiver

To The Physician:

I certify that of this date, __________, I have examined ________________________________ and found this person to be physically and mentally able to carry out the essential functions as assigned in the clinical setting as listed on the Essential Functions insert in this document, and I have verified the student is free of infectious disease (including tuberculosis) as confirmed by the lab tests and/or any other medical/laboratory test I have deemed necessary.

______________________________________ ______________________________

Signature of Physician or Nurse Practitioner **Phone**

______________________________________ ______________________________________

Please Print Physician or Nurse Practitioner Name **Address**

____

City **State** **Zip**

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Date of Signature

November, 2013

Hepatitis B Vaccination Waiver

(*To be completed only if the Hepatitis B Vaccine is declined or if the series has not been completed)*

I have read the Hepatitis B Vaccination information provided by the Calhoun Community College Health Division. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. Understanding the foregoing, I accept responsibility for making the decision to **decline** the HBV vaccine. I **DO NOT** consent to the administration of the vaccine. I understand the risks involved and I take full responsibility of any actual or potential hazards to my health. I agree to hold Calhoun Community College and all of its agents, officials, or employees harmless if I should contact this disease during or after my attendance at Calhoun Community College.

____ __________________________________

Student Signature **Date**

Proof of Health Insurance

I understand that, as a Health Division student at Calhoun Community College, it is strongly recommended that I have health insurance. I understand that if I experience injury or illness as a student fulfilling educational activities at a clinical facility, emergency treatment will be provided by that facility **at my expense**.

I have chosen **to provide proof of Health Insurance coverage** while enrolled in one of the Health Science programs and have supplied a copy of my insurance card to the Health Division. With that knowledge and understanding, and on behalf of myself, my heirs, and administrators, I hereby release Calhoun Community College, its employees, officials, agents, and representatives from any claim of liability for injury, loss, damage, or death that may result or arise from my experience as a student of the Health Sciences Division.

____ ________________________

Student Signature **Date**

****Please attach a copy of your health insurance card****

Health Insurance Waiver of Liability

I understand that, as a Health Division student at Calhoun Community College, it is strongly recommended that I have health insurance. I understand that if I experience injury or illness as a student fulfilling educational activities at a clinical facility, emergency treatment will be provided by that facility **at my expense**.

I have been informed of the importance of this recommendation and have elected to sign this waiver, verifying that I have **chosen not to have health insurance coverage**. With that knowledge and understanding, and on behalf of myself, my heirs, and administrators, I hereby release Calhoun Community College, its employees, officials, agents, and representatives from any claim of liability for injury, loss, damage, or death that may result or arise from my experience as a student of Health Sciences Division.

____ ________________________

Student Signature **Date**

Influenza Vaccination Refusal/Declination

I understand that, as a Health Division student at Calhoun Community College, I am required to provide documentation of the influenza vaccination or documentation of declination of the influenza vaccination. I understand this is a requirement of the clinical agency. I **DO NOT** consent to the administration of the influenza vaccine for the reason listed below and agree to attach the required documentation to validate the reasons for my declination: **Required documentation attached**.

Reason: ____

____

____ ________________________

Student Signature **Date**

TUBERCULOSIS SCREENING REQUIREMENT

All students entering a Health Sciences program at Calhoun Community College must submit documented results of a **two-step Mantoux PPD skin test** for tuberculosis. The test must be done **AFTER JANUARY 1** of the current year. ***The documented test results must be scanned or faxed to Employment Screening Services (ESS)***.

The Two-Step Mantoux PPD
The Mantoux test uses a syringe. A Tine Test uses a four-pronged puncture device (The Tine Test will not be accepted).

1. Have the **first** PPD skin test, have the results read and recorded within specified time period.

   AND

2. Have a **second** PPD skin test the **following week** and have these results read and recorded within specified time period.

Dates of each PPD and reading must be documented and **scanned or faxed to (ESS).** Students who have already submitted results of a two-step Mantoux PPD, must, thereafter, submit the results of a **yearly** Mantoux PPD with the **most recent** one having been done after **January 1 of the current year.**

ANYONE HAVING A POSITIVE PPD SKIN TEST FOR TB IN THE PAST SHOULD NOT HAVE THE PPD SKIN TEST REPEATED.

Should the **PPD skin test be positive** or if you have had a **positive PPD skin test** at anytime in the past, you must have the results of a **chest x-ray** done after January 1 of the current year. The results and a form completed by your physician must be **scanned or faxed to ESS.** (All forms can be obtained in the Health Division Office). To have the form mailed to you, please call (256) 306-2786 or (256) 306-2794. **Note: Chest X-Ray results are good for two (2) years. A positive TB skin test questionnaire must be completed each year.**

NOTE: Students who have already submitted results of a Two-Step Mantoux PPD, must thereafter submit the results of ONE yearly Mantoux with the most recent one having been completed after January 1 of the current year. Likewise, any student who can present documentation results of three (3) negative Mantoux PPD's given over the past three years (i.e. 2012, 2013 and the third on or after January 1 of the current year) will not be required to have a two-step Mantoux PPD. The last negative test must be after January 1 of the current year.

The **two-step PPD** skin test or the yearly PPD skin test can be obtained from your private physician. If you have any questions, please contact the Health Sciences Division at (256) 306-2786 or (256) 306-2794.

HEPATITIS B INFORMATION SHEET

Type B Hepatitis

Type B hepatitis is an infection of the liver caused by the hepatitis B virus (HBV). The hepatitis B virus is transmitted by infective blood or body fluids. Infective blood or body fluids can be introduced by contaminated needles, by unapparent or unnoticed contact with infectious secretions from skin lesions or mucosal surfaces, or through sexual contact.

Hepatitis B is the most commonly reported type of hepatitis in the United States. It is an unpredictable disease with a variety of presentations and outcomes. It is estimated that 60–75% of people who are infected do not become ill. In this circumstance prior infection can only be detected by presence of antibody in the blood. Acute symptomatic hepatitis B infection may result in serious liver injury which may incapacitate a person for weeks to months. Approximately 6–10% of persons with type B hepatitis become carriers of the virus and death occurs in 1–2 % of patients either as a result of acute liver failure or complications. Hepatitis B virus also has a role in the development of cirrhosis and liver cancer. There is no effective treatment for hepatitis B infection or disease.

Hepatitis B Vaccine

The Recombinant hepatitis vaccine is a genetically designed vaccine derived from yeast (not plasma). It is indicated for active immunization against infection caused by all known subtypes of hepatitis B virus. It will not prevent hepatitis caused by other agents, such as hepatitis A virus, non-A, non-B hepatitis viruses, or other viruses known to infect the liver. Full immunization requires three (3) intramuscular doses of vaccine given over a six month period. In an adult the vaccine should be administered in the deltoid muscle of the arm. The vaccine has been found to be effective in producing hepatitis B antibodies at protective levels in more than 90% of healthy individuals who received the recommended three doses of the vaccine in the deltoid muscle of the arm. The duration of immunity is unknown at this time. A small percentage of healthy persons do not respond to the vaccine and do not develop immunity to HBV. Antibody status can be determined by blood testing. Hepatitis B has a long incubation period. HBV vaccination may not prevent HBV infection in individuals who have an unrecognized HBV infection at the time of vaccine administration.

Possible Vaccine Side Effects

The observed incidence of side effects is very low. Injection site reactions consist principally of tenderness and redness. The most frequent systemic complaints include, but are not limited to, fatigue/weakness, headache, fever and malaise. It is not possible to contract hepatitis B from the vaccine since the vaccine is produced synthetically and not from human blood.

Who Should Consider The Vaccine

Vaccination is recommended by the Alabama Department of Public Health and the Centers for Disease Control (CDC) for persons of all ages who are or will be at increased risk of infection with HBV.

Health care workers who have direct clinical patient contact or handle potentially infective materials or items are considered to have an increased risk for contracting hepatitis B.

Contraindication

Vaccination is contraindicated for pregnant or nursing women and for anyone with hypersensitivity to yeast or any component of the vaccine. Persons experiencing hypersensitivity reactions after an injection of the vaccine should not receive further injections.

Student Vaccination

All students entering an Allied Health Department Program at Calhoun Community College are required to provide **documented proof** of completion of the hepatitis B vaccine series (three injections) or documented proof of immunity to hepatitis B or **sign a waiver refusing** the hepatitis B vaccination prior to registration for their first Allied Health Department class.

Your private physician can help you decide whether or not you should receive the hepatitis B vaccination series and can further discuss the possible side effects with you. If you decide to receive the hepatitis B vaccination series, you should contact your physician and arrange for its administration. Students are responsible for the full cost of the vaccine and its administration.

CLINICAL LABORATORY TECHNOLOGY
HEALTH SCIENCES DIVISION
ESSENTIAL FUNCTIONS

The **Essential Functions** are requirements for students entering and participating in the Clinical Laboratory Technician Program.

Requirements for students entering and participating in the Clinical Laboratory Technician Program include but are not limited to the ability to:

1. Accurately observe demonstrations and exercises in which biological fluids are being tested
   (Functional use of the senses: speak, smell, hear, vision, touch)
2. Use sufficient motor function to perform all tasks that are normally expected within the scope of practice for the practitioner in the workplace.
   (Standing, walking, hand-eye coordination, lift, reach, or transport supplies and equipment)
3. Measure, calculate, analyze, synthesize, integrate and apply information.
   (Critical thinking skills)
4. Possess the emotional health required to use their intellectual abilities fully, such as exercising sound judgment, promptly completing all responsibilities, being able to work in a changing and stressful environment, displaying flexibility and functioning independently in the face of uncertainties or problems that might arise.
5. Demonstrate professional demeanor and behavior and must perform in an ethical manner in dealing with peers, faculty, staff and patients; able to participate collaboratively and flexibly as a professional team member.
6. Obtain relevant information from lectures, seminars, laboratory sessions or exercises, computer documentation, clinical laboratory practicums and independent study assignments using the English language.

I have reviewed the **Essential Functions** for this program and I certify that to the best of my knowledge I have the ability to perform these functions. Describe any special accommodations requested:

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______________________________ __________________________
Student Signature **Date**