



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](http://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** \_\_\_\_\_

<b>Does student have any functional limitations or restrictions that would prevent him/her from working in a patient care area?</b>	<b>Yes</b>	<b>No</b>
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](mailto:pbaker@csc.edu) - [lwashi01@csc.edu](mailto:lwashi01@csc.edu)

COLUMBUS STATE COMMUNITY COLLEGE  
**SUPPLEMENTARY IMMUNIZATION RECORD**

**For Students in EMT-Paramedic, Histology, Medical Assisting, Nursing, Phlebotomy,  
 Practical Nursing, Respiratory, Surgical Technologies 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. **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.

THE FOLLOWING IMMUNIZATIONS ARE ***NOT REQUIRED***, BUT THEY ARE RECOMMENDED:

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

Date of immunization \_\_\_\_\_

**OR**

Date and results of mumps **IGG** titer \_\_\_\_\_

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

Date of immunization within past ten years \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_