HEALTH SCIENCE & FITNESS PATHWAY
STUDENT HEALTH RECORD

Program in which you are enrolling: _____ Campus: _____

All students enrolling in the health and early childhood programs must complete Part I of this form before consulting with a health care provider (MD/DO, PA, NP) to verify dates of immunizations and treatment of current or chronic conditions. With the exception of immunization information or in the case of medical emergencies, no information will be released to anyone other than the Health and Public Service Department without consent of the student.

Program continuation requires each student to perform every essential function of the student role. If the student, with reasonable accommodation, is unable to perform any essential function in a safe and successful manner, they will be required to withdraw from the program.

PART I: BACKGROUND INFORMATION **To be completed and signed by student (please print)

A **PERSONAL DATA** Gender: ☐ Male ☐ Female DMACC ID Number: _____

Last Name | First Name | Middle Initial | Date of Birth

Home Address (Number and Street) | City | State | Zip Code

Telephone: Home | Work | Health Insurance Company | Policy Number

( ) ( )

In Case of Emergency, Notify: Name | Relationship | Home Phone | Work Phone

B **PERSONAL HEALTH HISTORY**

.

DATE OF MOST RECENT DENTAL EXAM _____
month year

ALLERGIES: If none, write below None Known

Medication Allergies: _____

Other Types (Environmental, food): _____

I have the following "Med-alert" condition: _____ *(If none write NA)*

OTHER COMMENTS:

_____ _____
Student Signature Date

DMACC

Student Name_____

FORM TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

PART II: ***ALL fields must be completed, if not applicable, please list N/A***

1. **Physical/mental conditions which have required treatment within the last 6 months or are chronic in nature:**

_____

_____

_____

_____

2. **Medications taken currently or routinely:**

_____

_____

_____

_____

3. **Conditions which restrict activity and/or require special adaptation(s):**

_____

_____

_____

4. **Other:**

_____

_____

_____

5. **Core Performance Standards**:

Please refer to the attached **Iowa Core Performance Standards for Health Career Programs** and indicate if the above-named individual may have difficulty meeting any of the eleven standards outlined.

At this time this individual is capable of meeting the performance standards:

____ Agree.

____ Disagree. The following limitations are present_____

____ Additional evaluation suggested _____

6. **Date of Physical Exam: _____** mm/dd/yr (Within one year of program entry and annually thereafter.)

_____ _____

Date **Signature of Health Care Provider (MD, DO, ARNP, PA)**

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IOWA CORE PERFORMANCE STANDARDS

Iowa Community colleges have developed the following Core Performance Standards for all applicants to Health Care Career Programs. These standards are based upon required abilities that are compatible with effective performance in health care careers. Applicants unable to meet the Core Performance Standards are responsible for discussing the possibility of reasonable accommodations with the designated institutional office. Before final admission into a health career program, applicants are responsible for providing medical and other documentation related to any disability and the appropriate accommodations needed to meet the Core Performance Standards. These materials must be submitted in accordance with the institution's ADA Policy.

CAPABILITY	STANDARD	SOME EXAMPLES OF NECESSARY ACTIVITIES (NOT ALL INCLUSIVE)
Cognitive-Perception	The ability to gather and interpret data and events, to think clearly and rationally, and to respond appropriately	• Identify changes in patient/client health status • Handle multiple priorities in stressful situations
Critical Thinking	Utilize critical thinking to analyze the problem and devise effective plans to address the problem.	• Identify cause-effect relationships in clinical situations • Develop plans of care as required
Interpersonal	Have interpersonal and collaborative abilities to interact appropriately with members of the healthcare team as well as individuals, families and groups. Demonstrate the ability to avoid barriers to positive interaction in relation to cultural and/or diversity differences.	• Establish rapport with patients/clients and members of the healthcare team • Demonstrate a high level of patience and respect • Respond to a variety of behaviors (anger, fear, hostility) in a calm manner • Nonjudgmentalbehavior
Communication	Utilizecommunication strategies in English to communicate health information accurately and with legal and regulatory guidelines, upholding the strictest standards of confidentiality.	• Read, understand, write and speak English competently • Communicate thoughts, ideas and action plans with clarity, using written, verbal and/or visual methods • Explain treatment procedures • Initiate health teaching • Document patient/clientresponses • Validateresponses/messages with others
Technology Literacy	Demonstrate the ability to perform a variety of technological skills that are essential for providing safe patient care.	• Retrieve and document patient information using a variety of methods • Employcommunication technologies to coordinate confidential patient care
Mobility	Ambulatory capability to sufficiently maintain a center of gravity when met with an opposing force as in lifting,	• The ability to propel wheelchairs, stretchers, etc. alone or with assistance as available
Motor Skills	Gross and fine motor abilities to provide safe and effective care and documentation	• Positionpatients/clients • Reach, manipulate, and operate equipment, instruments and supplies • Electronicdocumentation/ keyboarding • Lift, carry, push and pull • Perform CPR
Hearing	Auditory ability to monitor and assess, or document health needs	• Hears monitor alarms, emergency signals, ausculatory sounds, cries for help
Visual	Visual ability sufficient for observations and assessment necessary in patient/client care, accurate color discrimination	• Observes patient/client responses • Discriminates color changes • Accurately reads measurement on patient client related equipment
Tactile	Tactile ability sufficient for physical assessment, inclusive of size, shape, temperature and texture	• Performs palpation • Performs functions of physical examination and/or those related to therapeuticintervention
Activity Tolerance	The ability to tolerate lengthy periods of physical activity	• Move quickly and/or continuously • Tolerate long periods of standing and/or sitting as required
Environmental	Ability to tolerate environmental stressors	• Adapt to rotating shifts • Work with chemicals and detergents • Tolerate exposure to fumes and odors • Work in areas that are close and crowded • Work in areas of potential physical violence • Work with patients with communicable diseases or conditions

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TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

Name_____ DMACC ID _____ Due date _____

Part III

Required Test and/or Immunizations

This form is to be completed, signed and dated by a licensed health care provider (MD, DO, ARNP, PA). Take your immunization records and documentation of disease with you to your appointment. If immunization records are not available, the HCP will determine what vaccinations tests or titers are indicated. **Documentation of the items below is required by the clinical agencies DMACC contracts with for clinical experience.**

- If using 2-step PPD Skin Test by Mantoux (NOT TINE): Induration greater than 10.0 mm requires chest X-ray and prophylactic treatment consideration. Thereafter, an annual TB test (single step only) will be required.
- QuantiFERON Gold blood test or T-spot TB blood test will also be acceptable and must be done annually. **Lab Report Required**

TB SKIN TEST	**Administered** There must be more than 7 days but less than 1 year between #1 skin test and #2 skin test				**Read** Read between **48** and **72** hours after administered		Results in mm induration **If POSITIVE, complete TB Symptoms Form**	
#1 TB skin test	**Date:**	**Time:**	**Location:**	**Signature:**	**Date:**	**Time:**	**Induration:**	**Signature:**
#2 TB skin test	**Date:**	**Time:**	**Location:**	**Signature:**	**Date:**	**Time:**	**Induration:**	**Signature:**

Adult Diphtheria/Tetanus/Pertussis All healthcare personnel (HCP) who have not or are unsure if they have previously received a dose of **Tdap** should receive a one-time dose of Tdap as soon as feasible. Tdap boosters are required every 10 years.	**Date of Tdap** mm/dd/yy

Varicella (Chicken Pox) Evidence of Immunity includes any one of the following: • Positive titer • Two doses of vaccine • Documentation by HCP of chickenpox or herpes zoster. **Verbal history is not acceptable**	**Must attach copy of Lab results** Titer Date mm/dd/yy	Titer Results	Vaccination #1 Date mm/dd/yy	Vaccination #2 Date mm/dd/yy	Documentation of HCP diagnosed Varicella or herpes zoster (Shingles). Include mm/dd/yy of diagnosis.
		Must attach copy of Lab results			
			First dose must be documented prior to submission of this health record and written verification of additional doses submitted as received.		

Hepatitis B **Evidence of immunity is mandatory for all* Health students and includes either** • **Completion of series, OR** • **Positive Titer of HBsAb**	**Titer HBsAb:** Results/Date **Must attach copy of Lab results**	**Date Dose #1** Required prior to submitting this record	**Date Dose #2 (1-2 months)** mm/dd/yy	**Date Dose #3 (4-6 months)**
	Must attach A copy of Lab results			

MMR All students must have documentation of either 2 MMR vaccinations **OR** Documentation of sufficient titers for Rubeola, Mumps and Rubella. Those who have an "indeterminate" or "equivocal" level of immunity upon testing should be considered non-immune. **Lab results of titers must be attached to this form.**	**Titers**	**Titer date** mm/dd/yy	Titer results **Must attach copy of Lab results**	**MMR Vaccination Dates**	
				Date MMR #1 mm/dd/yy	**Date MMR #2** mm/dd/yy
	Rubeola IgG		**Must attach copy of Lab results**		
	Mumps IgG		**Must attach copy of Lab results**		
	Rubella		**Must attach copy of Lab results**		

I certify this student has received the TB test and immunizations as indicated above or has laboratory evidence of immunity which is attached to this form.

_____ **Date:** _____

Print Name of Health Care Provider **Signature of Health Care Provider (MD, DO, ARNP, PA)**

_____ (____)_____

Address of Health Care Provider **City** **State** **Zip** **Phone**

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HEALTH SCIENCE & FITNESS PATHWAY
STUDENT HEALTH RECORD

ABSENCE OF TUBERCULOSIS SYMPTOMS FORM

To be used only if positive TB test

1. Have you ever had a history of a positive Mantoux (PPD, TST)? _____YES _____NO
2. Have you ever had a BCG Tuberculosis Vaccination? _____YES _____NO
3. When was your last chest x-ray? Date:_____
4. Have you had a persistent cough for more than 3 weeks? _____YES _____NO
5. Have you had any blood in your sputum? _____YES _____NO
6. Do you have pain in your chest when you cough? _____YES _____NO
7. Have you recently had a respiratory illness that did not respond to treatment? _____YES _____NO
8. Have you had an unexplained fever in the past 3-6 weeks? _____YES _____NO
9. Have you experienced any unintentional or unexplained weight loss? _____YES _____NO
10. Have you experienced any night sweats? _____YES _____NO
11. Have you experienced unexplained increased lethargy or fatigue? _____YES _____NO
12. Have you experienced and unexplained loss of appetite? _____YES _____NO
13. Have you been in close contact with an individual with known active tuberculosis? _____YES _____NO

Comments (Explain any YES answers above)

_____

_____

_____

Results:

____ No signs or symptoms of tuberculosis present.

____ Signs and symptoms of tuberculosis present. Follow-up with Primary Care Provider required.

Health Provider's Signature: _____

Title: _____ Date: _____

Clinic Address: _____ Clinic Name: _____

Student Name:_____

Exam Date:_____