STUDENT HEALTH HISTORY (please print in black ink) **To be completed by Student**

LAST NAME (print) FIRST NAME MIDDLE NAME SFSC STUDENT NUMBER

PERMANENT ADDRESS CITY STATE ZIP AREA CODE/PHONE NUMBER

DATE OF BIRTH (month/day/year) _____ **GENDER**: ☐ M ☐F **MARITAL STATUS**: ☐S ☐M ☐Other

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

FAMILY & PERSONAL HISTORY (please print in black ink) To be completed by student

Has any person, related by blood, had any of the following:

	Yes	No	Relationship		Yes	No	Relationship
Diabetes				Psychiatric illness			
Stroke				Suicide			
Glaucoma				Alcohol/Drug problems			
High blood pressure				Blood/clotting disorder			
Heart attack before age 55				Cholesterol or blood fat disorder			
Cancer (type:)				Respiratory Illness: (specify)			

HAVE YOU EVER HAD OR HAVE YOU NOW: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year		Yes	No	Year
Diabetes				Frequent sore throat			
Cardiovascular disease				Swelling of ankles, feet, or legs			
High blood pressure				Systemic lupus erythematosus			
Tuberculosis				Thyroid problems/disease			
Arthritis or joint problems				Frequent/Severe headaches			
Sickle cell/Anemia				Severe head injury or concussion			
Asthma/Respiratory illness				Persistent swollen glands in neck			
Bacterial endocarditis				Typhoid fever			
Chest pain upon exertion				Rheumatic fever			
Chicken Pox (Varicella virus)				Anxiety or Severe depression			
Chronic diarrhea				Pilonidal cysts (skin cysts)			
Epilepsy/Seizures				Mononucleosis			
Fainting spells/Dizziness				Neck injury			
Hearing deficit or loss				Back problems/Recurrent back pain			
Hepatitis				Heart problems/disease			
Hernia or rupture				Cardiovascular disease			
Herpes				Paralysis			
Immunosuppression				Varicose veins/painful leg veins			
Jaundice				Pertussis (whooping cough)			
Low blood pressure				Skin disease (eczema, psoriasis, etc)			
Malaria				Alcohol or Drug use			
Measles				Shortness of Breath			
Meningitis				Smoke: # of cigarettes a day _____			
Mumps				Hand or wrist problems			
Neurological disorders				Eye trouble excluding glasses			
Ulcer (duodenal or stomach)				Shoulder/Joint dislocations			
Protein or Blood in urine				Bronchitis or Pneumonia			
Sexually transmitted disease				Blood disease			
Psychiatric disorders				Emphysema			
Rubella				C.O.P.D.			
Sinus problems/Sinusitis				Broken bone: (specify)			
Tumor/Cancer: (specify)				Other: (specify)			

Please list any medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

FAMILY & PERSONAL HISTORY-CONTINUED (please print in black ink) **To be completed by Student**

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, rash, etc.) to any of the following? If yes, please fully explain the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Allergies	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine or other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies			
Latex products			
Do you have any other allergies or have you had any other reactions that are not mentioned above?			
Hospitalization/Surgery	**Yes**	**No**	**Explanation**
Have you ever been a patient in any type of hospital setting? (Specify when, where, and why)			
Have you ever been treated, hospitalized or are you presently on medication for emotional problems?			
Is there loss of or seriously impaired-function of any paired organ? (Please describe)			
Other than for a routine checkup, have you seen a physician or healthcare professional in the past 6 months? (Please describe)			
Have you ever had a serious illness or injury other than those already noted? (Specify when and where and give details)			
Medications	**Yes**	**No**	**Explanation**
Have you ever taken Pondamin, Redux, or Fen-Phen? (Specify when and for how long)			
Other	**Yes**	**No**	**Explanation**
Do you have any problems manipulating small objects with your fingers?			
Are you currently under the care of a physician for any other conditions? (Please describe)			

IMPORTANT INFORMATION…..PLEASE READ CAREFULLY AND COMPLETE

STATEMENT BY STUDENT:

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court order.

_____ _____

Signature of Student Date

PHYSICAL EXAMINATION (please print in black ink) **To be completed and signed by Physician**

Date of Examination MUST Be Within 1 Year of the First Day of Classes.

Last Name	**First Name**	**Middle Name**	**Date of Birth (month/day/year)**	**Examination Date**

HEIGHT _____ **WEIGHT** _____**Vital Signs: TPR** _____/_____/_____ **BP** _____/_____

(Specialist exams not required)

Vision: Corrected Right 20/_____
Left 20/_____
Uncorrected Right 20/_____
Left 20/_____
Color Vision

Hearing: (gross) Right _____
Left _____
15 ft. Right _____
Left _____

(Required tests)

Urinalysis: Sugar _____ Albumin _____
Micro _____
Hgb or Hct (if indicated) _____

Date _____ Results _____
Recommendations _____
_____
_____

Are there abnormalities?	Normal	Abnormal	**DESCRIPTION** (attach additional sheets if necessary)
1. Head, Ears, Nose, Mouth, Throat			
2. Eyes (Include glasses: reading/continuous)			
3. Cardiovascular (Heart/Circulation evaluation)			
4. Respiratory (Airway/Chest and Lungs)			
5. PPD (If positive, chest x-ray _____Date)			Date _____/_____ Results (If positive, attach report)
6. Abdominal			
7. Endocrine (Include thyroid problems/diabetes, etc.)			
8. Musculoskeletal/Neurological:			
a. Sensory (other than previously noted)			
b. Motor (condition of spine/extremities?)			
11. Skin (Include latex sensitivity)			
12. Rubella/Hepatitis Screen (If no immuniz. proof)			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical, psychological, or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity. Unlimited _____ Limited _____
Explain _____

D. Is student physically, psychologically, and emotionally healthy? Yes _____ No _____
Explain _____

Based on my assessment of this student's physical and emotional health on _____, he/she appears able to participate in all activities. Yes _____ No _____ If no, please explain _____
_____

_____ _____
Signature of Physician Date

_____ _____
Print Name of Physician State License Number

Health Sciences Student Health Form

Last Name	First Name	Middle Name	Date of Birth (month/day/year)

Part 1: Immunization Record, PPD and Titers: Please review student's health record and complete the following:

SECTION A - IMMUNIZATIONS

	Vaccination Date			
Tdap (must be within last 10 years)				
	MMR # (date)	MMR #2 (date)	Rubella Titer (IgG)	Rubeola Titer (IgG)
MMR (2 doses or titers with proof of immunity provided)			Immune	Immune
			No immunity	No immunity
	Hep B #1(date)	Hep B #2(date)	Hep B #3 (date)	
Hepatitis B Series (Must have first in series before start of program)				
	Date Administered	Date Read	Result	Provider Signature
Tuberculin (PPD) Test				
Chest x-ray (if positive PPD)				
	Vaccination Date			
Influenza Vaccine (prior to clinicals, during timeframe of October 1st – March 31st)				

SECTION B – REQUIRED TITERS

	Titer Date	Titer Results
Varicella Antibody Titer (if not immune, vaccination not required at this time)		Immune
		No immunity
Hepatitis C Antibody Titer (Current titer must be within 6 months of start of program)		Positive
		Negative
Hepatitis B Antibody Titer (IgG) (Upon completion of Hepatitis B series)		Immune
		No immunity

Part 2: Performance Ability:

1. Based on my assessment of this student's physical and emotional status he/she appears to be in good health and capable of performing the duties associated with their respective Health Sciences Program (Program Technical Standards attached)? ☐ **YES** ☐ **NO** (Please check one)

2. If you answered "NO" to the previous question, please document the condition(s) that will prevent this student from performing the duties of their respective Health Sciences Program. _____

_____

Must be completed by a licensed Physician (MD or DO), Physician Assistant or Nurse Practioner.

Provider Name: _____ Provider Phone#: _____

Provider Address: _____ Provider License #: _____

Provider Signature: _____ Date: _____

South Florida State College

Hepatitis B Vaccination and Titer Form

(This form to be used to document subsequent vaccinations & titer results)

Student Name: _____ Date of Birth: _____

1. Hepatitis B Vaccination Series:

Hep B #1 (date)	Hep B #2 (date)	Hep B #3 (date)

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

2. Titer to be done at least 6 weeks after completing Hepatitis B vaccination series:

Required Titer	Titer Date	Titer Results	Immune	Not Immune
Hepatitis B Antibody Titer (IgG)				

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

South Florida State College

Annual Tuberculosis Testing Form

(Required to submitted when PPD yearly update performed)

Student Name: _____ Date of Birth: _____

History of negative PPD: yearly update required

	Date Administered	Date Read	Result	Provider Signature
Tuberculin PPD Test				
Chest X-ray (if skin test positive)				

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

South Florida State College

Annual Influenza Vaccination Form

(All students must receive vaccination before clinicals during the timeframe of October 1st – March 31st)

Student Name: _____ Date of Birth: _____

	Date Administered	Injection Site & Lot Number
Influenza Vaccine		

Provider Name (printed): _____ Provider License #: _____

Provider Address: _____ Provider Phone #: _____

Provider Signature: _____ Date: _____

** Have provider complete and sign the above information or attach Proof of Immunization from provider **