Miami Dade College
Medical Campus

MIAMI DADE COLLEGE
MEDICAL CAMPUS

Student Health Record Form

Name: _____ **Student Number:** _____
Last **First** **Middle Initial**

I understand that student health information is protected and confidential under State of Florida and federal laws. I voluntarily provide, and consent to my medical provider or physician providing, the medical information contained in this document to the Miami Dade College and health care facilities that I am assigned to as part of Miami Dade College's medical program requirements. I also understand that all requested Student Health Record information is a prerequisite to enrollment in the clinical training of any Medical Center Campus program. Failure to complete this record will prevent my participation in the clinical training. The student and Health Care Examiner (MD, DO, PA, ARNP) must sign in the appropriate spaces provided on the form.

PERSONAL INFORMATION
All areas of this section must be completed. This information will be kept on file and used in the event that the student must be contacted, or an emergency contact is required.

1. **Drug Screening:** A minimum of a 10-panel drug screen is required. A second drug screen test may be required by some health care facilities. ***A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Campus program at Miami Dade College.*** **The results must be indicated and attached.**

2. **Tetanus & Rabies Vaccination**
   Students must provide documentation of the Tdap & Rabies vaccination within the last ten (10) years.

3. **Student's Statement**
   Student must read and sign this statement on page 3 of the Student Health Record.

4. **Examiner's Statement**
   The Health Care Examiner (MD, DO, PA, and ARNP) must read, sign, and confirm that the student can meet the Physical Demands associated with the program in the **Examiner's Statement Area on page 3** of the Student Heath Record.

Please Place Health Care Provider Office Stamp or Attach Business Card Here (Required)

PERSONAL INFORMATION

_____ Apt.#_____ _____

Address E-mail address

_____ _____ _____ Gender: M ____ F ____

City State Zip Code

_____ / _____ / _____ _____ _____

Date of Birth Home Telephone Number Cellular Phone Number

_____ _____ _____

Person to Notify in Emergency Relationship Contact Telephone Number

DRUG SCREENING

A **minimum** of a 10-panel drug screen is required. *A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Campus program at Miami Dade College.* The results must be indicated and attached.

TEST	DATE	RESULTS	
Drug Screen **(10 Panel)**	**____/____/____** **Month Day Year**	**Positive _____** **Negative_____**	***A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Center Campus program at Miami Dade College. RESULTS OF 10 Panel DRUG SCREEN TEST MUST BE ATTACHED.***

Tetanus) Vaccination

Students must provide documentation of the Tdap vaccination within the last ten (10) years.

Received: **____/____/____** (ATTACH COPY OF DOCUMENTATION)
Month Day Year

STUDENT'S STATEMENT

In order to satisfy medical program requirements, I hereby consent to the release and disclosure of my personal health information provided on the **Student Health Record Form** to Miami Dade College and any health care facility in which I am assigned for on-site clinical training. I understand that my personal health information is required to facilitate my participation in the clinical training, which is required for program completion. I also hereby release and hold harmless Miami Dade College and receiving health care facilities from any claim of violation of HIPAA or any other medical privacy rights that may arise for the release of my personal health information provided in the **Student Health Record Form**.

Print Name: _____

Student Signature:_____ Date:_____

PHYSICAL DEMANDS

In order to fulfill the requirements of the **Veterinary Technology** Program at Miami Dade College, students must be able to meet the physical demands associated with the profession. Examples of these requirements include but are not limited to the following:

Code: F = frequently O = Occasionally NA = Not Applicable

Physical Demands	Code	Comments
Standing	**F**	
Walking	**F**	
Sitting	**O**	
Lifting (up to 40 pounds)	**F**	
Carrying	**F**	
Pushing	**F**	
Pulling	**F**	
Balancing	**O**	
Climbing	**NA**	
Crouching	**F**	
Crawling	**O**	
Stooping	**F**	
Kneeling	**F**	
Reaching	**F**	
Manual Dexterity	**F**	
Tactile Dexterity	**F**	
Talking	**F**	
Hearing	**F**	
Seeing	**F**	
Communicating	**F**	

(For specific Performance Standards associated with the **Veterinary Technology** Program, please contact the Program Coordinator at 305-237-4473.

Limitations: _____

_____

EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this document and that the information about the test results are correct. This individual can participate in all activities required to provide health care to patients in an acute or chronic care facility, emergency setting or any other situation that is part of the learning experiences in the designated health care program. The student is able to meet THE PHYSICAL DEMANDS that are listed above. **(List any limitations associated with this student in the area provided).**

_____ _____

MD/DO/PA/ARNP Signature Date

_____ _____

Office Telephone Number License Number