

**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. **Documentation of all titers, vaccines, drug screening, TB testing, and x-rays must be attached to the student health record.**

**SECTION 1: 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.

**SECTION 2: REQUIRED INFLUENZA INJECTION (FLU SHOT)**

Students participating in a clinical rotation must receive the influenza injection. Students that cannot participate in the influenza injection process as a result of a medical condition or refuse to participate in the influenza injection may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize the student's ability to participate in the clinical portion of a Medical Campus program. It is highly recommended that all students receive the influenza injection.

**SECTION 3: REQUIRED TITERS/TESTS**

**A. Varicella (Chicken Pox):** A Varicella Titer must be drawn and ***the results attached. A record of the Varicella Vaccine will not be accepted as documentation of the required titer.*** The date of the titer and results must be indicated in the appropriate area. **(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).**

**Mumps, Rubeola (Measles), and Rubella (German Measles):** A Mumps, Rubeola, and Rubella Titer must be drawn and ***the results attached. A record of the MMR (Mumps, Measles, Rubella) Vaccine will not be accepted as documentation of the required titer.*** The dates of the titers and the results must be indicated in the appropriate area. **(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).**

**B. TB Skin Test:** Two consecutive TB Skin Tests are required. The TB Skin tests can be repeated a minimum of seven days apart. ***The dates and results of each TB Skin Test must be attached.*** The Skin Tests must have been performed within the last three (3) months to be considered a recent test. Results from QuantiFERON are acceptable within the last three (3) months.

**Chest X-ray:** A recent Chest x-ray is required if a positive TB skin Test or QuantiFERON is reported or there is a history of a positive TB Skin Test. The chest x-ray must have been completed within the last three (3) months to be considered current. ***Results must be attached.***

**C. 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.***

**Section 4: Hepatitis B Vaccine**

Students must provide documentation of the initiation or completion of the Hepatitis B vaccine series at the time of application. It is highly recommended that the student complete the series while enrolled in the program. Further information of the Hepatitis B Vaccine is provided on the Student Health Record Form on page 3. **The results must be attached.**

**Section 5: Tdap (Tetanus, Diphtheria, Pertussis) Vaccination**

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

Name: \_\_\_\_\_ MDID: \_\_\_\_\_  
Last First Middle Initial

**Section 6: Student's Statement**

Student must read and sign this statement on page 3 of the Student Health Record.

**Section 7: 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 4 of the Student Health Record.

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

**SECTION 1: PERSONAL INFORMATION**

_____	Apt.# _____	_____
Address		E-mail address
_____	_____	_____
City	State	Zip Code
____/____/____	_____	_____
Date of Birth	Home Telephone Number	Cellular Phone Number
_____	_____	_____
Person to Notify in Emergency	Relationship	Contact Telephone Number

**SECTION 2: INFLUENZA INJECTION (Documentation must be attached)**

Date of injection: \_\_\_\_\_

I understand that if I cannot participate in the influenza injection process as a result of a medical condition or refuse to participate in the influenza injection, I may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize my ability to participate in the clinical portion of a Medical Campus program.

STUDENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**SECTION 3: REQUIRED TITERS/TESTS**

**Parts A, B, C: THESE BOXES ARE TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL ONLY**

**A. REQUIRED TITERS: (Documentation must be attached)**

A Varicella (Chickenpox), Mumps, Rubeola (Measles), and Rubella (German Measles) Titer must be drawn and the results attached. **A record of Vaccines WILL NOT BE ACCEPTED as documentation for the required titers.** The dates of the titers and the results must be indicated in the appropriate area below. *(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).*

TITER	DATE	LAB RESULTS (Documentation must be attached) (Numerical Value of Results Must Be Reported Below)	Please Circle
Varicella (Chickenpox) Titer	____/____/____ <small>Month Day Year</small>		Immune/ Not Immune
Mumps Titer	____/____/____ <small>Month Day Year</small>		Immune/ Not Immune

Name: \_\_\_\_\_ MDID: \_\_\_\_\_  
 Last First Middle Initial

Rubeola (Measles) Titer	____/____/____ Month Day Year	Immune/ Not Immune
Rubella (German Measles) Titer	____/____/____ Month Day Year	Immune/ Not Immune

**B. TB SKIN TEST/ QUANTIFERON /CHEST X-RAY**

Two consecutive TB Skin Tests are required. *The TB Skin tests can be repeated a minimum of seven days apart.* The dates and results of each TB Skin Test must be attached. The Skin Tests must have been performed *within the last three (3) months* to be considered a recent test. Results from QuantiFERON are acceptable. **In the event the results indicate a positive skin test or QuantiFERON, or the student has a history of a positive TB skin test, a chest x-ray is required. The chest x-ray must have been completed within the last three (3) months to be considered current. Results must be attached.**

TEST	DATE	RESULTS	
TB Skin Test 1 <sup>st</sup> Test	____/____/____ Month Day Year	Positive _____ Negative _____	If positive skin test, current chest x-ray is required. <b><u>Results of TB skin test must be attached.</u></b>
TB Skin Test 2 <sup>nd</sup> Test	____/____/____ Month Day Year	Positive _____ Negative _____	If positive skin test, current chest x-ray is required. <b><u>Results of TB skin test must be attached.</u></b>
QuantiFERON	____/____/____ Month Day Year	Positive _____ Negative _____	If positive, current chest x-ray is required. <b><u>Results of QuantiFERON must be attached.</u></b>
Chest X-ray	____/____/____ Month Day Year	Positive _____ Negative _____	<b><u>RESULTS OF CHEST X-RAY MUST BE ATTACHED</u></b>

**C. 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 _____	<b><i>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.</i></b>

**SECTION 4: HEPATITIS**

**Introduction:** Health care professionals are at risk of exposure to blood and body fluids contaminated with the viruses that cause HIV and Hepatitis. Consistent use of Standard Precautions is the best known means to avoid transmission of these viruses or other contaminants. Students will be taught Standard Precautions before they provide care to any patient in the clinical setting. Although it is rare, a health care worker may become exposed to one of these viruses through accidental transmission. Currently, there is no vaccine that protects against the HIV virus. However, the Hepatitis B vaccine is an effective means of preventing Hepatitis B. As a student who will be providing direct patient care, you should discuss this vaccine with your health care provider.

**About the Vaccine:** The Hepatitis B Vaccine is a genetically engineered "yeast" derived vaccine. It is administered in the deltoid muscle (arm) in a series of three doses over a six month period. You should seek additional information about the vaccine from your health care provider; especially if you have an allergy to yeast or may be pregnant, or are a nursing mother.

I have initiated the Hepatitis B Vaccine Series with my first dose listed below: **(ATTACH COPY OF DOCUMENTATION)**

1<sup>st</sup> Dose: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_      2<sup>nd</sup> Dose: \_\_\_\_/\_\_\_\_/\_\_\_\_      3<sup>rd</sup> Dose: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ MDID: \_\_\_\_\_  
Last First Middle Initial

(One month after 1<sup>st</sup> dose)

(Six months after 1<sup>st</sup> dose)

**OR**

I have already completed a Hepatitis B Vaccine Program with dates of injections listed below: **(ATTACH COPY OF DOCUMENTATION)**

1<sup>st</sup> Dose: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

2<sup>nd</sup> Dose: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(One month after 1<sup>st</sup> dose)

3<sup>rd</sup> Dose: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Six months after 1<sup>st</sup> dose)

**OR**

Antibody testing has revealed that I have immunity to Hepatitis B. Yes \_\_\_\_\_ No \_\_\_\_\_

**(ATTACH COPY OF LAB REPORT).**

**SECTION 5: Tdap (Tetanus, Diphtheria, Pertussis) Vaccination**

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

Received: \_\_\_\_/\_\_\_\_/\_\_\_\_ (ATTACH COPY OF DOCUMENTATION)  
Month Day Year

**SECTION 6: 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 Phlebotomy 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		Perform with or without reasonable accommodations. Manipulate equipment weighing approximately 25 pounds.
Walking		
Sitting		
Lifting (up to 125 pounds)	NA	

