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, and 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 or positive titer results. It is highly recommended that the student complete the series while enrolled in the program. However, students may decline the vaccine. A decline attestation is found on page 3. **A record of the Hepatitis B Vaccine or antibody test 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.

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**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 Heath Record.

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

## SECTION 1: 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

## 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** | ____/____/____ Month Day Year | | **Immune/ Not Immune** |
| **Mumps Titer** | ____/____/____ Month Day Year | | **Immune/ Not Immune** |

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

**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**_____ | ***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.*** |

**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)**

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

1st Dose: Date:____/____/____ 2nd Dose:____/____/____ (One month after 1st dose) 3rd Dose:____/____/____ (Six months after 1st dose)

***OR***

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

1st Dose: Date:____/____/____ 2nd Dose:____/____/____ (One month after 1st dose) 3rd Dose:____/____/____ (Six months after 1st dose)

***OR***

Antibody testing has revealed that I have immunity to Hepatitis B. Yes _____ No _____
**(ATTACH COPY OF LAB REPORT).** ***OR***

I understand that, due to my occupational exposure to blood or other potentially infectious materials, I am at risk of acquiring Hepatitis B infection. I understand that the Hepatitis B Vaccine is recommended to help prevent illness due to the Hepatitis B Virus. I have discussed the risks and benefits with my personal health care provider and ***decline*** the Hepatitis B Vaccine at this time.

Student Signature: _____ Date: _____

## 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:_____

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

**PHYSICAL DEMANDS**

In order to fulfill the requirements of the Physician Assistant 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** | Possess the physical and mental stamina to meet the demands associated with extended periods of sitting, standing, moving, and physical exertion required for satisfactory performance in the clinical and classroom settings. |
| **Walking** | **F** | |
| **Sitting** | **F** | |
| **Lifting (up to 125 pounds)** | **O** | |
| **Carrying** | **F** | |
| **Pushing** | **O** | |
| **Pulling** | **O** | |
| **Balancing** | **F** | |
| **Climbing** | **O** | |
| **Crouching** | **O** | |
| **Crawling** | **O** | |
| **Stooping** | **O** | |
| **Kneeling** | **O** | |
| **Reaching** | **F** | |
| **Manual Dexterity** | **F** | |
| **Feeling** | **F** | |
| **Talking** | **F** | Students should be able to speak intelligibly, hear sufficiently; elicit and transmit patient information in oral and written English to members of the healthcare team. Communicate effectively and sensitively with patients. Students must possess demonstrated reading skills at a level sufficient to accomplish curricular requirements and provide clinical care for patients. |
| **Hearing** | **F** | |
| **Seeing** | **F** | |
| **Communicating** | **F** | |

(For specific Performance Standards associated with the PA Program please contact the Program Coordinator at 305-237-4103.

Limitations: _____

**SECTION 7: 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