Information you have provided will not be used to influence your admission into the health care program of your choice. It will be used, if necessary, solely as an aid to providing necessary health care while you are a student.

MOTT COMMUNITY COLLEGE
DIVISION OF HEALTH SCIENCES
HEALTH HISTORY & PHYSICAL FORM

This information is strictly for the use of Health Sciences and will not be released to anyone without your knowledge and consent.

Student ID: _____

PART A - Health History

This part is to be completed by the STUDENT ONLY

PLEASE COMPLETE ALL SECTIONS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

_____

Last Name **First Name** **Middle Name**

_____

Home Address *(Number and Street)* **City or Town** **State** **Zip Code**

_____

Home Telephone Number **Date of Birth**

_____

Name of Next of Kin **Relationship**

_____

Address **Emergency Telephone Number**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Other *(Please check appropriate box)***

Sex: ☐ **Male** ☐ **Female**

Health Science Program Of Study You Are Entering:_____

(Dental Assisting, Dental Hygiene, Health Unit Coordinator, Nursing, Occupational Therapy Assistant, Physical Therapist Assistant, Respiratory Therapy

Please answer the following questions:	**Yes**	**No**
Has your physical activity been restricted during the past five years? (Give reasons and durations)		
Have you had difficulty with school, studies, or teachers? (Give details)		
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problems? (Give details)		
Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
Have you been consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years? Other than routine checkups? (Give Details)		
Have you been rejected for or discharged from military service because of physical, emotional, or other reasons?		
Do you have any questions in regards to your health, family history, or other matters which you would like to discuss with a member of the Health Services Office?		

Student Comments:

Student Signature **Date**

PART B – Physical Examination, Immunizations, Titer Results

This part is to be completed by the Physician/Authorized Health Care Provider ONLY

TO THE EXAMINING PHYSICIAN/AUTHORIZED HEALTH CARE PROVIDER:
Please review the student's history and complete all sections of the physician's form. Please comment on all positive answers. This information supplied will not affect his/her status. It will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of Health Sciences and will not be released without student consent.

(ATTACH COPY OF LAB REPORT WITH RESULTS OF TITER, OR IMMUNIZATION RECORD)

MEASLES TITER LEVEL (Rubeola): Date: _____
IMMUNE_____NON-IMMUNE_____
MUMPS TITER LEVEL: _____Date: _____
IMMUNE_____NON-IMMUNE_____
RUBELLA TITER LEVEL: _____ Date : _____
IMMUNE _____NON-IMMUNE_____

OR

MMR VACCINE –1st and 2nd DOSE
If no immunity to **Measles, Mumps and Rubella**

Dates: _____/__/_____ _____/__/_____
(month/day/year) (month/day/year)

Date of Last **TETANUS/DIPTHERIA**
(must be within last 10 years)
(Tdap)____/_____/_____
(month/day/year)

HEPATITIS B VACCINE (Recommended)
1st Dose Date_____/____/____
(month/day/year)
2nd Dose Date_____/____/____
(month/day/year)
3rd Dose Date_____/___/_____
(month/day/year)

VARICELLA (Chicken pox)
Does the student have a *reliable* history of **Varicella**? **Yes ☐ No ☐**
If no, the student is to receive two doses of **Varicella** vaccine.
1st Dose Date _____/____/____ 2nd Dose Date_____/____/____
(month/day/year) (month/day/year)

INFLUENZA VACCINE *(Annual)
Date _____/_____/_____
month/day/year)

MANTOUX/TUBERCULIN TEST
**** (Required ANNUALLY) ****

DATE ADMIN.	DATE READ	POSITIVE	NEGATIVE
(Please attach documentation of test results)			

CHEST X-RAY (If history of positive skin test)

(Please attach chest x-ray report)

Date: _____

Results:

TWO-STEP TB testing (two separate skin test, 1-3 weeks apart) are required for the following programs: Nursing, Occupational Therapy Assistant, Physical Therapist Assistant & Respiratory Therapy Assistant.
ONE TB test is required for the Dental Hygiene, Dental Assisting, Health Unit Coordinator & Phlebotomy Programs

VISION SCREENING
RIGHT_____ LEFT_____

HEARING SCREENING
RIGHT_____ LEFT_____

CORRECTED VISION
RIGHT_____ LEFT_____

COLOR BLINDNESS (NRSG & RT STUDENTS ONLY)
PASS_____FAIL_____

ALLERGIES:	Yes	No
Penicillin		
Sulfonamides		
Serum		
Latex		
Food:		
Other:		

Notes from Physician:

Are there any abnormalities of the following systems?			
	Yes	**No**	**If yes, describe fully below:**
Head, Ears, Nose, or Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Dental			
Speech			

Physician Comments?

Recommendations for physical activity in the health occupation program (walking, ability to lift safely, motor coordination, etc.): ☐ Unlimited ☐ Limited, please explain:

_____

_____

Do you have any recommendation regarding the care of the student? ☐ Yes ☐ No

_____

_____

Is the student now under treatment for any medical or emotional condition? ☐ Yes ☐ No

_____

_____

Physician's/Authorized Health Care Provider's Signature
(Acknowledge Review of Health History)

First Name: _____ Last Name: _____
Address: _____
Telephone Number: _____ Date: _____
Physician Signature: _____

Student Consent

I hereby give my consent for Mott Community College's Health Sciences Division to share with the Program Coordinators and assigned clinical sites, information as appropriate, concerning my health status.

_____
Student's Signature

_____
Date

THE INFORMATION IS CURRENT FOR (3) YEARS FROM EXAMINATION DATE.