

Blinn College Allied Health Programs

Please Check the appropriate program:

- | | |
|---------------------------------|-----------------------------------|
| <input type="checkbox"/> ADN | <input type="checkbox"/> PTA |
| <input type="checkbox"/> DENTAL | <input type="checkbox"/> RAD TECH |
| <input type="checkbox"/> EMS | <input type="checkbox"/> VOCN |
| <input type="checkbox"/> FIRT | Brenham _____ |
| | Bryan _____ |

Allied Health Campus, P.O. Box 6030, Bryan, TX 77805-6030

Fax: (979) 209-7524

Report of Medical History

Last Name		First	Middle	Maiden
Address - Number & Street		City	State	ZIP
Phone	Date of Birth	SS#	Sex	

Emergency Notification

Person to notify in case of emergency

Last Name		First	Middle
Address - Number & Street		City	State ZIP
Home Phone	Work Phone	Pager	Relationship

Personal History

ANSWER ALL QUESTIONS. EXPLAIN "YES" ANSWERS BELOW:

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
Measles (rubeola)			Seizures		
Mumps			Dizziness, Fainting		
Rubella (German Measles)			Weakness, Paralysis		
Chicken Pox (varicella)			Joint Problems		
Diabetes			Back Problems		
Tuberculosis			Gastrointestinal Problems		
Hepatitis A/B/C			Heart Problems		
Visual Impairment			Malignancy		
Hearing Impairment			Respiratory Problems		
Surgery			Hernia		
Recurrent Headache			Allergies		
Any UNEXPLAINED weight loss (greater than 10 pounds)?					
Have you had any illness/injury or been hospitalized other than already noted?					
Is your ability to practice safe professional medical care adversely affected by a physical or mental disability/illness which may endanger the health and safety of persons under your care?					

EXPLAIN "YES" ANSWERS, INCLUDING DATES OF DISEASE(S): _____

(Student) I verify that all of the above is true and complete to the best of my knowledge.

Student Signature

Date

NOTE: BACKSIDE OF FORM TO BE COMPLETED BY HEALTH CARE PROVIDER

Report of Health Evaluation

TO THE EXAMINING PHYSICIAN: Please review the students' history and complete the physician's form. Please comment on all positive answers. This information will be used only as a background for providing health care, if necessary.

Student Name			SSN
Blood Pressure	Height in inches	Weight in pounds	

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS?			
SYSTEM	YES	NO	COMMENTS
Head/Ears/Nose/Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Gynecological/OB			
Are there any speech/vision/hearing impairments?			
Eyes			Vision: Lt. Rt. Corrected: Yes No
Hearing			Hearing: Lt. Rt. Corrected: Yes No

In your opinion, is this individual in suitable physical and emotional condition for this Allied Health Program: Unlimited Limited Please explain: _____

_____ Physician's Signature				_____ Date
_____ Print Last Name		_____ First		_____ Phone (voice)
_____ Address	_____ City	_____ State	_____ Zip	_____ Phone (fax)

This form can be hand-carried in sealed envelope by student, or returned by mail to the appropriate Blinn College Allied Health Program. Please, in keeping with HIPAA rules, NO faxes. Address on front of this form; Attention specific program name

Tests and Immunizations Required by Texas State Law/Clinical Facilities

This form is provided for your benefit. If immunization records are provided on another document, this form need not be completed and returned.

Last Name	First	Middle	SSN#
Tuberculin Skin Test: (PPD - TB Test) OR Chest X-ray (required IF skin test is positive) <i>Must Have Been Tested within Past 6 Months</i>		<input type="checkbox"/> Positive <input type="checkbox"/> Negative Date _____	X-ray results: _____
Diphtheria, Tetanus (TD): One dose within 10 years		Date of Immunization: _____	
Measles (Rubeola) Those born on or after January 1, 1957, must show proof of either: A. Two doses of measles vaccine by/or after their first birthday and at least 30 days apart* OR B. Record of physician-diagnosed measles OR C. Serologic test positive for measles antibody		Date _____	Date _____
Mumps Those born on or after January 1, 1957, must show proof of either: A. One dose of mumps vaccine of or after their first birthday* OR B. Record of physician-diagnosed mumps OR C. Serologic test positive for mumps antibody		Date _____	Date _____
Rubella Those born on or after January 1, 1957, must show proof of either: A. One dose of Rubella vaccine of or after their first birthday* OR B. Record of physician-diagnosed Rubella OR C. Serologic test positive for Rubella antibody		Date _____	Date _____
Varicella (Chicken Pox) Must show proof of either: A. Record of physician-diagnosed Varicella OR B. Serologic titer positive for Varicella antibody OR C. One dose of Varicella vaccine		Date _____	Date _____
Hepatitis B Vaccine: MANDATORY FOR <u>ALL</u> ALLIED HEALTH STUDENTS. The student should be aware that there is potential of exposure to Hepatitis B during clinical assignments. Immunization schedule would include three vaccines over a period of 3-6 months. Series should be well underway by time of admission to the program and completed before being allowed in clinical.		Date of first vaccine: _____	Date of second vaccine: _____
		Date of third vaccine: _____	Titer: Date _____ + -

* Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible.

(Student) I verify that all of the above is true and complete to the best of my knowledge, under penalty as prescribed in student contract for falsification of records.

_____ Student Signature

_____ Date

* See reverse side

Consent and Release Form

I, _____, hereby assume all risks in connection with and fully release Blinn College, its agencies and/or employees from any injury or damage to me, and hereby acknowledge my understanding of this.

Signature: _____
Applicant

Date: _____

Witness: _____

Date: _____

If you have elected not to take the HIV test, please complete the following statement.

I, _____, having been informed of the risks, have elected not to take the HIV test.

Signature: _____
Applicant

Date: _____

Witness: _____

Date: _____

Name:	Allied Health Program:	ID#:
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**BLINN COLLEGE
ALLIED HEALTH PROGRAMS**

Drug Screen

NOTE: Procedure(s) for collecting drug screen specimen(s) will be done by either the student's personal physician or an approved laboratory or Medical Review Officer (MRO), using National Institute on Drug Abuse (NIDA) guidelines. If the student's healthcare provider does not do this type of testing, he/she can refer the student to an appropriate NIDA lab.

The student is expected to disclose current use of any drug or alcohol, including prescription medications for specific health conditions. The prescreening method will involve a collection (observed or unobserved, depending on healthcare provider) of urine and/or blood. The Substance Abuse Panel 10 (SAP 10), with integrity checks for Creatinine and Ph levels will be the standard test done, as well as Blood Alcohol Test (BAT) when appropriate. SAP 10 or BAT results that fall outside any of the acceptable ranges are considered positive test results and are automatically sent for a separate confirmatory test by a GAS Chromatography Mass Spectrometry (GCMS) method. If the results remain positive, they will be sent to the student's physician or a MRO. If a MRO has to be utilized, there may be a separate cost (\$25-75.00) to the student, since it is a separate service.

The SAP 10 tests for the following may be reported on this form or on the Laboratory's own form:

Drug:	Results:
Amphetamines	
Barbiturates	
Benzodiazepines	
Cocaine metabolites	
Marijuana metabolites	
Methadone	
Methaqualone	
Opiates	
Phencyclidine	
Propoxyphene	
Alcohol	

Comments: