CENTRAL OHIO TECHNICAL COLLEGE
Newark • Coshocton • Knox • Pataskala

**Institute of Public Service and Safety**
1179 University Drive
Newark, Ohio 43055
Phone: 740-755-7090
Fax: 614-367-0418
www.cotc.edu

# Health Examination Report

| Last Name | First Name | MI | Date |
|---|---|---|---|
| | | | |

I understand that health information is protected and confidential under State of Ohio and federal laws. I voluntarily provide and consent to my medical provider or physician providing the medical information contained in this document to Central Ohio Technical College and understand that admission is contingent upon a physical exam including the Health Examination Report. Failure to complete this record will prevent my participation in the clinical/field program. My health care provider (MD, DO, PA, and ARNP) must sign in the appropriate spaces provided on the form. Documentation of all titers, skin 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/field rotation must receive the influenza injection. Students that cannot participate in the influenza injection process as a result of a medical condition or religious beliefs may be required to participate in additional measures established by Grant EMS Education. Additionally, it may jeopardize the student's ability to participate in the clinical/field portion of the 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, Rubella (Measles), and Rubella (German measles**): A Mumps, Rubella, and Rubella Titer must be drawn and the results attached. A record of the MMR (Mumps, Measles, and 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 DOCUMENTATIONIN THIS AREA).

**B** **2-Step TB Skin Test**: Two consecutive TB Skin Tests are required. The TB Skin tests can be repeated a minimum of three 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. **In the event the results indicate a positive skin test or the student has a history of a positive TB skin test, a chest x-ray is required.**

**Chest X-ray:** A recent Chest x-ray is required if a positive TB skin Test 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**.

**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. However students may decline the vaccine. A decline attestation is provided. **A record of the Hepatitis B Vaccine or antibody test results must be attached**.

**SECTION 5: Tdap VACCINE (Tetanus-Diphtheria-Pertussis)**

Students must provide documentation of the Tdap vaccine in the last 10 years at the time of application. **A record of the Tdap vaccination must be attached**.

**SECTION 6: STUDENT'S STATEMENT**

Student must read and sign this statement 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**

| | | | |
|---|---|---|---|
| **Street Address** | | **Email Address** | |
| **City** | | **State** | **Zip** |
| **Date of Birth** | **Home Number** | **Cell Number** | |
| **Name of Emergency Contact** | | **Relationship** | **Contact Number** |

**SECTION 2: INFLUENZA INJECTION**

| | |
|---|---|
| **Date of Injection** | I understand that if I cannot participate in the influenza injection process as a result of medical condition, religious beliefs, or otherwise refuse to participate in the 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 the program. (current prior to the start of clinicals) |
| **Student Signature** | **Date** |

**SECTION 3: REQUIRED TITER/TESTS**

**Parts A and B are to be completed by Authorized Personnel ONLY**

A. **REQUIRED TITERS:** (documentation must be attached) A Varicella, Mumps, Rubeola (Measles), and Rubella (German Measles) Titer must be drawn and the results attached.

| TITER | DATE | LAB RESULTS Documentation must be attached. Numerical value of results must be reported | PLEASE CIRCLE |
|---|---|---|---|
| **Varicella Titer** | | | **Immune/ Not Immune** |
| **Mumps Titer** | | | **Immune/Not Immune** |
| **Rubeola (Measles) Titer** | | | **Immune/Not Immune** |
| **Rubella (German Measles) Titer** | | | **Immune/Not Immune** |

B. **2-STEP TB SKIN TEST/CHEST X-RAY:** Two consecutive TB Skin Tests are required.

| TEST | DATE | | RESULTS |
|---|---|---|---|
| **TB Skin Test 1st Test** | _____/_____/_____ | **Positive** ☐ **Negative** ☐ | **If positive skin test, current chest x-ray is required. Results of TB test must be attached.** |
| **TB Skin Test 2nd Test** | _____/_____/_____ | **Positive** ☐ **Negative** ☐ | **If positive skin test, current chest x-ray is required. Results of TB test must be attached.** |
| **Chest X-Ray** | _____/_____/_____ | **Positive** ☐ **Negative** ☐ | **RESULTS OF CHEST X-RAY 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 HOV and Hepatitis. Consistent use of Standard Precautions is the best known means to avoid transmission of these viruses or other contaminates. 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 with my first dose listed below:

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

**OR**

I have already completed a Hepatitis B Vaccine Program with dates of injections listed below:

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

**OR**

Antibody testing had revealed that I have immunity to Hepatitis B. Yes___ No___ (Attach a Copy of the 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) VACCINE:**

Health care professionals are at risk of exposure to diseases such as Tdap. Students must provide documentation of the Tdap vaccine within the last 10 years at the time of application. Should the Tdap extend beyond the 10 years during enrollment in the program, a Tdap boost will be required to attend clinical.

Last Tdap Date: ____/____/____

**Section 6: Student Statement:**

In order to satisfy medical program requirements, I hereby consent to the release and disclosure of my personal health information provided on the Health Examination Report to COTC EMS Education 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 COTC 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 Health Examination Report.

| |
|---|
| Print Name |

| |
|---|
| Student Signature Date |

**HISTORY AND PHYSICAL EXAM**

| **Height** | **Weight** | **L Eye** | **R Eye** | **Both** | **Corrective Lenses Yes___ No___** |
|---|---|---|---|---|---|
| **Head** | | | | | |
| **Ears/Nose/Throat** | | | | | |
| **Neck** | | | | | |
| **Chest/Lungs** | | | | | |
| **Heart** | | | | | |
| **Abdomen** | | | | | |
| **Extremities** | | | | | |
| **Back** | | | | | |
| **History of any Chronic Illness** | | | | | |
| **List ALL regular Medications** | | | | | |
| **Any Physical Limitations?** | | | | | |
| **Standing** Yes___ No___ | **Pushing** Yes___ No___ | **Crawling** Yes___ No__ | **Feeling** Yes___ No___ | **Walking** Yes____ No___ | |
| **Sitting** Yes___ No___ | **Pulling** Yes___ No___ | **Stooping** Yes___ No___ | **Talking** Yes___ No___ | **Balancing** Yes___ No___ | |
| **Kneeling** Yes___ No___ | **Hearing** Yes___ No____ | **Carrying** Yes___ No___ | **Crouching** Yes___ No___ | **Manual Dexerity** Yes___ No___ | |
| **Lifting (up to 125 pounds)** Yes___ | **Climbing** Yes___ No___ | **Reaching** Yes___ No___ | **Seeing** Yes___ No___ | **Communicating** Yes___ No___ | |
| | | | | | |

**SECTION 5: 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 patients in an acute or chronic care facility, emergency setting or any other situation that is part of the learning experiences in the EMS/Paramedic 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