HEALTH EXAMINATION RECORD

Prior to admission to an Allied Health Program, candidates must meet the Technical and Academic Standards established by the Center for Allied Health. If, after reviewing the candidates Health Examination Record, the Admissions Committee has questions regarding the candidate's ability to meet the Health Standards, the Center for Allied Health reserves the option to request further evaluation of the candidate's qualifications. The information requested in the Health Examination Record is in compliance with the American Disabilities Act [ADA] and Equal Opportunity Commission [EEOC] Standards.

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

SOCIAL SECURITY#: _____ COUNTY: _____

PHONE NUMBERS HOME: _____ CELL: _____

EMAIL ADDRESS: _____ DATE OF BIRTH: _____

EMERGENCY CONTACT NAME & PHONE:

_____

_____

Check the appropriate curriculum in which the student is to be enrolled:

☐ (CE) Clinical Medical Assistant CMA (Certificate)
☐ (CE) Phlebotomy (Certificate)
☐ (CE) Sterile Processing Technician (Certificate)
☐ (CE) Certified Nursing Assistant CNA (Certificate)
☐ (CE) Certified Medicine Aide (Certificate)

The following tests, documentation of results, and health exam are required PRIOR to beginning of the program. The following tests, results, dates and provider's certification are required.

I have reviewed this immunization history for completeness and agree to release the information listed in the student health packet to authorized members of the Chesapeake College staff and authorized staff of cooperating clinical agencies, as directed by Chesapeake College throughout the duration I am enrolled.

Student Signature: _____ Date: _____

Student Name (Print): _____

PERSONAL HEALTH HISTORY

Medical provider must fill out completely. Please indicate past or present conditions.
Please do not leave dates and reactions blank, mark with n/a or cross out.

Immunizations: **Results must be attached to this form.** Titers must include a numerical result or numerical reference range. If non-immune, booster is required

1. COVID-19 vaccine (Not required for CNA or Phlebotomy)
   Please submit proof in the form of your COVID-19 vaccination record card.

1. COVID-19 vaccine
   First Dose _____/_____/_____
   Second Dose _____/_____/_____

2. Influenza vaccine

2. Influenza vaccine
   Month _____ Day _____ Year _____

3. PPD Skin Test: A TINE TEST IS NOT ACCEPTABLE.
   2 PPDs (a skin test for TB) is required unless there is a history of positive PPD. This requires 4 visits to the healthcare provider; 2 injections and 2 readings. Alternatively, a TB Blood draw (QuantiFERON or T-Spot) is accepted in place of the skin tests. Both PPD skin tests must be within the last three months.
   If the PPD reaction is greater than 10mm, (positive reaction), a chest x-ray is required.
   Results must be attached to this form.

3. PPD Results: **ATTACH RESULTS TO THIS FORM.**
   Date _____/_____/_____ Reaction _____
   Date _____/_____/_____ Reaction _____
   QuantiFERON-TB Gold Plus
   Date _____ Results _____
   Chest X-Ray (Attach copy of x-ray report)
   Date _____ Results _____

4. MMR IMMUNITY:
   Confirmation of immunity to Rubeola, Rubella and Mumps is required.
   Confirm by titer and attach titer results to this form.

4. Rubeola Titer: **ATTACH RESULTS TO THIS FORM.**
   Date _____ Results _____
   Immune: ☐ Yes ☐ No
   Rubella Titer: **ATTACH RESULTS TO THIS FORM.**
   Date _____ Results _____
   Immune: ☐ Yes ☐ No
   Mumps Titer: **ATTACH RESULTS TO THIS FORM.**
   Date _____ Results _____
   Immune: ☐ Yes ☐ No

5. Varicella (Chicken Pox)
   Confirm by titer and attach titer results to this form.

5. Varicella Titer: **ATTACH RESULTS TO THIS FORM.**
   Date _____ Results _____
   Immune: ☐ Yes ☐ No

6. Hepatitis B (HBV) (Waiver Available)
   1st _____
   2nd _____
   3rd _____

All students must receive a complete series of Hepatitis B Vaccine, show serologic confirmation of immunity to Hepatitis B virus, or sign a waiver declining vaccine.

7. TDaP vaccine (Not required for CNA)

7. TDaP vaccine
   Month _____ Day _____ Year _____

Date of Birth _____/_____/_____ Blood Pressure _____/_____ Pulse _____ Height _____ Weight _____

VISUAL ACUITY: For:
Corrected Both: 20/_____
Right: 20/_____
Left: 20/_____

Do you have any chronic health conditions? ☐ Yes ☐ No If yes, specify:

Do you have any restrictions to physical activity (lifting; bending; turning; limitations to fine movements e.g. ability to manipulate instruments)? ☐ Yes ☐ No If yes, specify:

Are you currently under medication? ☐ Yes ☐ No If yes, specify medical condition:

HEALTH STANDARDS REQUIRED FOR ADMISSION TO CHESAPEAKE COLLEGE ALLIED HEALTH PROGRAMS

To Be Reviewed by Provider

QUALIFICATIONS: Good physical and mental health.

ADMISSION CRITERIA: Student must possess sufficient stamina and mental stability to fulfill the requirements of the program and the customary requirements of the profession:

- Work for 8-12 hours performing physical tasks requiring physical energy without jeopardy to patient and student safety (strenuous physical activities include but are not limited to: lifting, pushing, pulling, stooping, walking and carrying more than 50 pounds).
- Performing fine movements and be able to manipulate instruments and equipment.
- Establish and work toward goals in a consistently responsible, realistic manner.
- Have auditory ability sufficient to monitor and assess health needs.
- Have visual ability sufficient for observation and assessment necessary for patient care.

RECOMMENDATIONS: Specify any recommendation(s) for treatment, restriction of academic load, and/or restriction of physical activity, etc:

PROVIDER'S CERTIFICATION: On the basis of the Personal Health History and the Physical Examination, I certify that _____ meets the health standards listed above as established by the Center for Allied Health and is, therefore, qualified as a candidate for selection into an Allied Health Program.

Provider's Phone	Date:	Provider's Name (Please Type or Print)

Street

City	State	Zip	Provider's Signature

Please fax completed documents to 410-827-5817,
or mail them to CE Healthcare, PO Box 8, Wye Mills, MD 21679.