



HEALTH EXAMINATION RECORD

Student must complete this first page.

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.

STUDENT NAME: _____ PHONE NUMBER: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

EMAIL ADDRESS: _____ DATE OF BIRTH: _____

Check the appropriate curriculum in which you would like to be enrolled:

(CE) Clinical Medical Assistant CMA (Certificate)

(CE) Certified Nursing Assistant CNA (Certificate)

(CE) Phlebotomy (Certificate)

(CE) Certified Medicine Aide (Certificate)

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:

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 this page completely and **attach supporting documentation**.

Influenza vaccine: Month _____ Day _____ Year _____

PPD Skin Test: 2 PPDs is required unless there is a history of positive PPD; 2 injections and 2 readings. 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. Alternatively, a TB Blood draw (QuantiFERON or T-Spot) is accepted in place of the skin tests. **Attach results.**

PPD Results: 1st Date _____ Reaction _____ 2nd Date _____ Reaction _____

QuantiFERON-TB Gold Plus: Date _____ Results _____

Chest X-Ray (IF needed. Attach copy of x-ray report): Date _____ Results _____

MMR IMMUNITY (see below): **CNA only** attach titer results to this form. **Other programs** attach vaccination records.

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

Varicella Titer (Attach results to this form): Date _____ Results _____ Immune: Yes No

Hepatitis B (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): 1st _____ 2nd _____ 3rd _____

Tdap vaccine (Medical assistants only): Month _____ Day _____ Year _____

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 (including but 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.
- 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 Name (Please Print): _____ Date: _____ Street: _____

City: _____ Zip: _____ Provider's Signature: _____

Please send completed documents to CEHealthcare@chesapeake.edu or fax to 410-827-5817