DURHAM TECHNICAL COMMUNITY COLLEGE
HEALTH AND WELLNESS DEPARTMENT

The Student Medical Form is required by clinical agencies for students to be able to participate in clinical experiences. Each program will indicate to students when these forms are to be completed. It is expected that the student will submit an honest and accurate record. Omissions, whether intentional or not, are in violation of the College's Academic Honesty policy. Any student found in violation of this policy will not be permitted to participate in clinical and may be dismissed from the College.

Once the Medical Form is completed and submitted to the program, **the student is responsible for notifying the program in writing of ANY changes to the Medical Form within 5 business days of the change (e.g. injury, pregnancy or other condition that could affect participation in clinical). Such changes may require an additional attestation by a physician of your ability to participate in clinical.** Failure to follow these procedures will lead to the student's inability to participate in clinical.

Students should follow these guidelines when completing the Student Medical Form:

- Each program will notify the student when this form is due. Failure to submit the information by the due date may result in the inability to progress in the program or dismissal from the program.
- Refusal to obtain required immunizations (or titers) may result in the inability to progress or dismissal from the program.
- This form should be completed no more than six (6) months (or longer if indicated) before the student begins the clinical program by the physician, physician assistant or nurse practitioner familiar with the student and his/her medical history.
    - If you are being treated for any medical or mental condition that requires continued treatment or monitoring, you MUST have the physician who is treating you fully complete the Physical Examination and the Required Medical Assessment section on the form.
    - If you are not being treated currently for a medical condition, you may have any physician, physician assistant or nurse practitioner complete the medical part of the form.
- Be sure that the physician, physician assistant, or nurse practitioner completes the immunization record and physical examination forms **and** he/she **SIGNS (not a signature stamp)** and dates the form. The form also requires an official office stamp in addition to the signature and date.
- The Immunization Record is extremely important. To avoid problems completing this information, read the Guidelines for Completing Immunization Record (see page 2). If you have any questions, please refer them to the Clinical Coordinator for the program.
- If the student is not continuously enrolled (i.e. is not enrolled for a consecutive Spring and Fall semester), then the student must obtain a new medical form for the program.

When the Medical Form is complete, the ***student should make a copy for his/her personal records*** and **SIGN** this form which is to be submitted with the original medical form to the program. Please contact the Clinical Coordinator for the program if you have any questions.

I am submitting this completed Medical Form and attest that it is true and complete to the best of my knowledge. I understand that if anything on this form changes while I am a student in a health program, I must notify the program director in writing within 5 business days of the change.

_____	_____	_____
Student Name (Print)	Student Signature	Date

PERSONAL INFORMATION (to be completed by the student) *Please print in black ink.*

Last name (Print) First Name Middle/Maiden Name Student ID#

Address City/State/Zip Code Area Code/Phone Number

Date of Birth _____ Gender: • M • F Email: _____

Semester entering (circle): Fall Spring Summer 20___

_____

Name of Person to Contact In Case of Emergency Relationship

_____

Address City/State Zip Code Area Code/Phone Number

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

KEEP A COPY OF ALL FORMS YOU SUBMIT FOR YOUR RECORDS

IMPORTANT- The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Acceptable records of your immunizations may be obtained from any of the following: (Be certain that your name and date of birth appears on each sheet. The records must be in black ink and the dates of vaccine administration must include the month, day, and year.)

- High School Records- These may contain some, but not all, of your immunization information. Contact Student Services for help if needed. **Your immunization records do not transfer automatically. You must request a copy.**
- Personal Shot Records- Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department
- Military Records or WHO (World Health Organization documents)
- Previous College or University- **Your immunization records do not transfer automatically. You must request a copy.**

IMMUNIZATION RECORD (To be completed and signed by physician, PA or NP. A complete immunization record from a physician or clinic may be attached to this form.) ***Please print in black ink.***

Last Name **First Name** **Middle/Maiden Name** **Date of Birth**

SECTION A: REQUIRED IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
Tdap (within 10 years)				
Td booster				
MMR (2 doses or positive titer) **OR**				***Titer Date & Result
Measles (2 doses or positive titer)				***Titer Date & Result
Mumps (2 doses or positive titer)				***Titer Date & Result
Rubella (2 doses or positive titer)				***Titer Date & Result
Varicella (2 doses or positive titer)				***Titer Date & Result
Influenza vaccine				
COVID19 vaccination and booster				
Tuberculin (PPD) Test within 12 months or risk assessment and symptom screening. **If your instructor advises you that a 2 step PPD is required, the results are recorded in the boxes to the right.**		Date read:	(TB Test #1)	(TB Test #2)
		mm induration:		
-----OR-----QuantiFERON®–TB Gold In-Tube blood test (QFT-GIT)		Results (pos/neg):		
-----OR-----Chest X-ray, if the PPD is positive (or documentation of screening annually on Department of Health and Human Services "Result of TB Screening")		Date of x-ray:		
		Results of x-ray:		
Treatment (if applicable):				

SECTION B: RECOMMENDED IMMUNIZATIONS The following immunizations are recommended for all students BUT may be required by certain programs and clinical agencies. Please consult your program material for specific requirements.

	mo./day/year	mo./day/year	mo./day/year	***Titer Date & Result
Hepatitis B vaccine (3 dose series) **OR** Heplisav-B (2 doses, 4 weeks apart) **OR** positive titer				
Hepatitis A/B combination series (3 dose series) **OR** positive titer				
Meningococcal conjugate or MenACWY vaccines (Menactra(r) and Menveo(r)) **and/or** *Serogroup B meningococcal or MenB vaccines (Bexsero(r) and Trumenba(r))				

*****Attach Lab report**

Signature REQUIRED (NO STAMP):

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____

Print Name of Physician/PA/NP **Date**

Office Address **City/State/Zip Code**
OFFICE STAMP:

PHYSICAL EXAMINATION (To be completed and signed by physician, PA or NP.) *Please print in black ink.*

Last Name **First Name** **Middle/Maiden Name** **Date of Birth**

Address **City/State/Zip Code** **Area Code/Phone Number**

Height _____ **Weight** _____ **TPR** _____/_____/_____**BP** _____

Vision: Corrected Right 20/____ Left 20/____ Uncorrected Right 20/ ____ Left 20/____ Color Vision	**Hearing:** (gross) Right _____Left_____ 15 ft. Right_____ Left_____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

REQUIRED MEDICAL ASSESSMENT (To be completed and signed by physician, PA or NP.)

A. Based on my assessment of this student's physical and emotional/psychological health on _____(date), he/she appears to be able to comply with the essential skills of the program (attached), participate in the activities of a health professional in a clinical setting, and provide safe care to the public. YES_____ NO _____

B. Recommendations for physical activity (during patient care activities): Unlimited _____ Limited _____

Explain:

_____

_____

Signature REQUIRED (AND OFFICE STAMP IF AVAILABLE):

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____

Print Name of Physician/PA/NP **Date**

_____

Office Address **City/State/Zip Code**
OFFICE STAMP: