STUDENT HEALTH FORM

Copies of original lab reports and medical documents are required and must be included for compliance.

Phlebotomy Technician Program Date: ________________

Student Name:		
Date of Birth:	SS#:	
Address:		
City:	State:	Zip:
Phone Numbers:	Home:	Cell:

Ethnicity (Select One):

☐ American Indian or Alaska Native ☐ Hispanic/Latino ☐ Asian ☐ Bi/Multiracial
☐ Native Hawaiian or Other Pacific Islander ☐ White/Caucasian ☐ Black/African American ☐ Unknown

Mandatory Immunizations for Students Participating in Clinical Experience

1. Covid Vaccination (MANDATORY) Date #1: _______________ #2_______________ (if applicable)	2. Flu Vaccine (MANDATORY) *Required annually* Date: ____________________________
3. Quantiferon-TB Blood Test *PPD results are not accepted.* Date of collection: ____________________________________	Results: __________________________
4. Baseline Chest X-ray (for positive TB results only) *(Copies of original documentation of positive results, x-ray report, and physician statement of clearance required).* Date: ____________________________	Results: __________________________

5. MMR (Measles, Mumps, Rubella) Series of 2 vaccines or proof of immunity by titer level (requires blood draw). If titers are negative or equivocal, student must participate in vaccination series. Do not test for immunity of two vaccination dates are documented.

Dose #1 Date:	Rubeola Titer Date:	POS / NEG / EQIV
Dose #2 Date:	Mumps Titer Date:	POS / NEG / EQIV
	Rubella Titer Date:	POS / NEG / EQIV

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6. Tetanus/Diphtheria/Pertussis (TDaP) Booster must be within 10 years. Date:
7. Hepatitis B (HBsAB) Titer Level (MANDATORY) Hep B Titer Date: POS / NEG / EQIV
If titer is negative or equivocal, student must participate in vaccination series.
8. Varicella (Chicken Pox) Series of 2 vaccines. Date #1: Date #2:
Or
Date of Titer: POS / NEG / EQIV
If titer is negative or equivocal, student must participate in vaccination series. History of chicken pox is not accepted.

Certification and Consent

I certify that to the best of my knowledge the information provided (including any attached copies) is true and correct. I also give my consent for the release of any immunization records to the faculty/staff at the Technical College of the Lowcountry. I further consent to the release of my immunization records to any clinical facility that I may be sent to for clinical rotations. I agree to inform TCL of any changes in medications or medical conditions. Failure to comply may result in dismissal from the course or program of study.

Student Signature: ______________________________________

Date Signed: ______________________________________

PAGE 3 MUST BE COMPLETED BY HEALTHCARE PROVIDER

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THIS SECTION MUST BE COMPLETED BY HEALTHCARE PROVIDER

Student Name: _________________________________ Program: Phlebotomy Technician Program

To the examining medical practitioner:
This applicant is considering admission into a Health and Wellness program at Technical College of the Lowcountry. To ensure the health and safety of patients and healthcare providers while enrolled, this person will be required to: participate in a rigorous academic program; be involved in stressful situations on a one-to-one basis; be called upon to work with groups of people in stressful situations; be required to effectively use all sensory organs; engage in activities that require above-average manual dexterity; and be required to be on his/her feet for 4 to 15 consecutive hours at any given time.

Physical Examination Record

Eyes : Corrected vision	Yes	No	Ears: Corrected hearing:	Yes	No
Nose			Abdomen		
Throat			Hernia		
Mouth			Nervous System		
Neck			Skin		
Breasts			Orthopedic		
Lungs			Psychiatric		
Cardiovascular			Other		

Allergies: ____

Limitations/Special Accommodations/Medical Concerns

Please note below any physical, mental, emotional abnormalities, any medications, diseases, and/or medical concerns which might in any way interfere with the student's safety and/or the student's ability to provide safe patient care.

**** Due to course requirements, pregnant students require medical clearance no sooner than 4 weeks prior to clinical externship start.**

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Medications

Please list all medications that the student is currently taking. (Attach additional medication sheet if needed.)

Medication	Dosage	Indication

Certification of Health Status

I hereby certify that I have examined _________________________________ and that he/she is physically and emotionally able to be enrolled as a health and wellness student. To the best of my knowledge, on this date, I have determined that he/she is free from any health requirement that is of potential risk to patients or that might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs and substances that may alter the individual's behavior.

Signature of Physician or Certified Nurse Practitioner: ____ Date: _______________

Print Name and Title: ____ License No. _____________________________________

Street Address: ____

City: ________________________________ State: ____________________ Zip: _______________

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