STUDENT HEALTH RECORD

Moreno Valley College

This program requires verification of health status and proof of immunization records prior to the beginning of the clinical portion of the program. It is necessary to provide the following health status items. Please have your Healthcare provider complete this form. Submit the completed form with proof attached to back (after making a copy for your records) to Bob Fontaine at Ben Clark Training Center (16888 Bundy Ave, Riverside, Ca 92518). If you have any questions or concerns, please us at (951) 571-6393.

TO BE COMPLETED BY THE STUDENT:

STUDENT NAME: _____ STUDENT ID #: _____

ADDRESS: _____
(Street) (City) (Zip)

TELEPHONE: _____
(Daytime) (Evening)

Student Health History

(To be completed by the student **prior** to giving the **Student Health Record** to the Healthcare provider)

PAST HEALTH HISTORY

1. **ILLNESSES** – Check YES or NO. If YES, indicate year in which condition occurred and describe any YES responses, by number, at the end of this section.

	YES	NO	DATE
RECENT HISTORY			
1. Fever	____	____	_____
2. Chills	____	____	_____
3. Weight Loss	____	____	_____
4. Loss of energy/fatigue	____	____	_____
EYES			
5. Poor vision	____	____	_____
6. Color Blindness	____	____	_____
7. Double Vision	____	____	_____
8. Injury to Eye	____	____	_____
9. Cataract	____	____	_____
10. Glaucoma	____	____	_____
11. Wear glasses/contacts	____	____	_____
EARS			
12. Ear Infection	____	____	_____
13. Mastoid surgery	____	____	_____
14. Loss of hearing	____	____	_____
15. Ringing in ears	____	____	_____
16. Hearing aid	____	____	_____
NOSE			
17. Allergies	____	____	_____
18. Sinus trouble	____	____	_____
19. Hay fever	____	____	_____
20. Frequent colds	____	____	_____
21. Sore throat	____	____	_____
22. Frequent hoarseness	____	____	_____
23. Dental problems	____	____	_____
24. Frequent nosebleeds	____	____	_____

STUDENT NAME:_____

YES NO DATE **STUDENT ID #: _____**

LUNGS

25. Tuberculosis ____ ____ _____
26. Chest surgery ____ ____ _____
27. Asthma ____ ____ _____
28. Lung collapse ____ ____ _____
29. Breast surgery ____ ____ _____
30. Pneumonia ____ ____ _____

31. Shortness of breath ____ ____ _____
32. Chronic cough ____ ____ _____
33. Night cough ____ ____ _____
34. Chest pain ____ ____ _____
35. Wheezing ____ ____ _____
36. Emphysema ____ ____ _____

HEART

37. Heart surgery ____ ____ _____
38. High blood pressure ____ ____ _____
39. Heart murmur ____ ____ _____
40. Enlarged heart ____ ____ _____
41. Heart disease/failure ____ ____ _____
42. Rheumatic fever ____ ____ _____
43. Heart palpitations ____ ____ _____
44. Heart attack ____ ____ _____
45. Heart medication ____ ____ _____

CIRCULATION

46. Varicose veins ____ ____ _____
47. Stroke ____ ____ _____
48. Leg ulcers ____ ____ _____
49. Swelling of ankles ____ ____ _____
50. Leg pain on walking ____ ____ _____

BLOOD

51. Anemia ____ ____ _____
52. Leukemia ____ ____ _____
53. Other Blood diseases ____ ____ _____

ENDOCRINE

54. Diabetes ____ ____ _____
55. Pituitary problems ____ ____ _____
56. Thyroid problems ____ ____ _____
57. Cancer or tumors ____ ____

HEAD

58. Headaches ____ ____ _____
59. Head injury ____ ____ _____
60. Neck injury ____ ____ _____

MUSCULOSKELETAL

61. Birth defects ____ ____ _____
62. Frequent backaches ____ ____ _____
63. Back surgery ____ ____ _____
64. Disc disease ____ ____ _____
65. Back injury or strain ____ ____ _____
66. Back X-Rays ____ ____ _____
67. Chiropractic treatment ____ ____ _____
68. Arthritis ____ ____ _____
69. Rheumatism ____ ____ _____
70. Swollen joints ____ ____ _____
71. Amputation ____ ____ _____
72. Broken bones ____ ____ _____
73. Dislocations ____ ____ _____
74. Painful feet ____ ____ _____
75. Rheumatoid arthritis ____ ____ _____
76. Physical limitation ____ ____ _____
77. Lifting Restrictions ____ ____ _____
78. Carpal tunnel ____ ____ _____
79. Arm, elbow injury ____ ____ _____
80. Shoulder injury ____ ____ _____
81. Wrist, hand injuries ____ ____ _____

GASTROINTESTINAL

82. Ulcers ____ ____ _____
83. Colitus ____ ____ _____
84. Diarrhea (frequent) ____ ____ _____
85. Stomach problems ____ ____ _____
86. Vomiting ____ ____ _____
87. Blood in stool ____ ____ _____
88. Hepatitis ____ ____ _____
89. Cirrhosis ____ ____ _____
90. Yellow jaundice ____ ____ _____
91. Gallbladder trouble ____ ____ _____
92. Gall stones ____ ____ _____

NERVOUS SYSTEM

93. Epilepsy/seizures ____ ____ _____
94. Fainting spells ____ ____ _____
95. Loss of consciousness ____ ____ _____
96. Dizziness or Vertigo ____ ____ _____
97. Frequent exhaustion ____ ____ _____
98. Trouble with nerves ____ ____ _____
99. Worry/depression ____ ____ _____

SKIN

100. Skin allergies ____ ____ _____
101. Skin problems ____ ____ _____
102. Reaction: Chemicals ____ ____ _____
103. Reaction: Medicines ____ ____ _____
104. Eczema ____ ____ _____
105. Acne ____ ____ _____

STUDENT NAME:_____ STUDENT ID# _____

DESCRIBE FULLY ANY *"YES"* RESPONSES BY NUMBER:

NUMBER	DESCRIPTION

HOSPITALIZATIONS AND OPERATIONS (*Example: 1980 appendectomy)*

1.	3.
2.	4.

I, the undersigned, certify that I have provided accurate and complete information regarding my health.

_____ _____

Student Signature Date

Remainder of Health Record to be completed by Healthcare Provider

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Respiration: _____ Temp: _____

CLINICAL EVALUATION: (CODE: □=NORMAL RANGE; **+** =ABNORMAL; **N/A** =NOT EXAMINED)		
ITEM	CODE	DESCRIPTION OF ITEMS
1. SKIN		
2. LYMPHATICS		
3. HEAD AND NECK		
4. EYES		
5. EARS		
6. NOSE		
7. MOUTH, ORAL CAVITY		
8. CHEST AND LUNGS		
9. EXTREMITIES		
10. ABDOMEN		
11. HERNIA		
12. MUSCULOSKELETAL		
13. BACK AND SPINE		
14. NEUROLOGICAL		

STUDENT NAME:_____ **STUDENT ID#**_____

IMMUNIZATION STATUS

1. Tetanus Immunization Current/Tdap w/in10yr: Yes _____ No _____
   Date _____
2. MMR Immunization status Current: Yes _____ No _____
   (Given as an adult or titer immune) Date _____
3. Tuberculin Skin Test/PPD
   (RESULTS MUST BE WITHIN 90 DAYS OF PROGRAM ENROLLMENT)
   Date: _____ Reaction: _____ Provider Initials _____
4. X-Ray (Required if PPD is positive) Date _____ Result _____
5. Varicella Titer (Required) Titer Immune Yes _____ No _____
   Date _____
6. Hepatitis B Titer (Required) Titer Completed Yes _____ No _____
   (Post series) Test Performed _____ Date _____
7. Recombivax HB given? Yes Hep b#1 _____ #2 _____ #3 _____ No _____
8. Flu Vaccination (must be current for the year) Yes _____ No _____

EVALUATION AND RECOMMENDATIONS

Based on the information provided to me by the patient concerning his/her past medical history, the tasks inherent to the position, as well as the current physical findings, I find that the aforementioned individual:

☐ is capable of performing the required tasks.

☐ is not capable of performing the required tasks.

I hereby certify that as of this date _____, this student is cleared to perform routine healthcare education functions in the clinical setting. This student does not have any health condition that will create a hazard to himself/herself, fellow students, facility employees, or patients and their visitors.

PROVIDER'S SIGNATURE: _____

PLEASE PRINT OR TYPE BELOW:

HEALTHCARE PROVIDER: _____

ADDRESS: _____

TELEPHONE: _____