Moreno Valley College

STUDENT HEALTH RECORD

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 as adult: 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: _____