LORD FAIRFAX COMMUNITY COLLEGE

Office of Health Professions

EMS Programs

MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM

Name:

Address:
_____

Telephone:_____

Date of Physical Examination:

Medical Office Name and Contact Information:
_____
_____

Please attach any supporting documentation.

This form must be completed by your health care provider.

PHYSICAL EXAMINATION:

T_____ P _____ R _____ B/P _____ Wgt: _____ Hgt: _____

Eyes:
Vision (R) _____ (L) _____ With Correction: (R) _____ (L) _____

Ears:
(R) _____ (L) _____ Hearing: (R) _____ (L) _____

Mouth (Teeth/Gums/Tonsils):_____

Nose/Sinuses: _____

Neck/Thyroid: _____

Lungs/Thorax: _____

Heart/Vascular: _____

Breasts: _____

Abdomen/Hernia: _____

External Genitalia/Rectum: _____

Musculoskeletal/Posture: _____

Skin: _____

(continued)

MEDICAL HISTORY

Allergies:
N/A

Current Medications:
N/A

Acute Illnesses, Operations, Injuries/Dates: _____

Chronic Illnesases/Date(s) and Duration:
N/

Does this student have a history of or is he/she receiving treatment for:

Tuberculosis: N/A Epilepsy: N/A

Diabetes: N/A Migraine Headaches: N/A

List any physical disabilities or limitations that may limit performance or affect ability to meet clinical criteria and identify specific limitations:

Sensory Deficit (identify specific): N/A

Mental / Emotional Disability: N/A

To your knowledge, has this student been treated for any disorder that may interfere with their performance as a student nurse?

Yes: _____ No: _____

If yes, please comment: _____

Signature of Health Care Provider: _____ Date: _____

(continued)

This form must be completed by your health care provider.

HEPATITIS B (Strongly Recommended)

Immunization #1 Date: (**M/D/Yr**) #2 Date: (**M/D/Yr**) #3 Date: (**M/D/Yr**)

Hepatitis B Titer-Date: _____ (**M/D/Yr**) Results: _____(Immune) _____(Non-immune)

REQUIRED IMMUNITY

ENTIRE section MUST be completed to comply with health and immunization requirements of selected clinical laboratory sites. Non-compliant students will not be allowed in the clinical areas.

Student Name: _____ Birth date (M/D/Yr): _____

MEASLES, MUMPS AND RUBELLA

(Students are required to have **2 dates** of MMR vaccine **OR** attach a copy of **immune titer results** and record below)

Date (**M/D/Yr**) of MMR #1 : _____

Date (**M/D/Yr**) of MMR #2 : _____

OR

Rubeola Titer – Date: _____ (**M/D/Yr**) Results: _____(Immune) _____(Non-immune)

Mumps Titer – Date: _____ (**M/D/Yr**) Results: _____(Immune) _____(Non-immune)

Rubella Titer – Date: _____ (**M/D/Yr**) Results: _____(Immune) _____(Non-immune)

VARICELLA

(Students are required to have **2 dates** of Varicella vaccine **OR** attach a copy of **immune titer results** and record below)

Dates (**M/D/Yr**) of immunization: #1 _____ #2 _____

OR

Varicella Titer – Date (**M/D/Yr**): _____ Results:_____(Immune) _____(Non-immune)

Tdap (Tetanus, Diphtheria, and Pertussis)

is required unless Tetanus (or Td) booster was given within the past two years, please indicate, and Tdap vaccine will be withheld. (See additional information below)

Tdap Date (**M/D/Yr**): (Tetanus or Td Booster Date (**M/D/Yr**):

Note on Tdap (Tetanus, Diptheria and Pertussis): Students (Medical, nursing, respiratory therapy, physical therapy, radiology, etc.) must fulfill the requirements of the Tdap policy that applies to all VHS employees and states that employees will have a Tdap unless there is documentation that they have received a Tetanus (or Td) the 2nd year booster within the last two (2) years. The employee/student must give evidence of Tdap immunization after anniversary of the Tetanus (or Td) booster.

TUBERCULIN (PPD) SKIN TEST (MUST BE REPEATED ANNUALLY):

Date Given: _____ Date Read: _____ Results: _____ (Negative) _____ (Positive**)

**Chest X-ray ONLY REQUIRED if TST (PPD) is positive. Chest x-ray date: _____

Documentation of treatment will need to be attached (past or current).

Documentation of treatment (Yes / No) _____

★ **Note:** Any ***Non-immune*** result on a titer **REQUIRES** the administration of new immunizations.

Signature of Health Care Provider: _____ Date: _____