Curriculum: **MEDICAL ASSISTANT/PHLEBOTOMIST**

PHYSICIAN'S PHYSICAL FOR CLINICAL ROTATIONS

HEALTH INFORMATION FOR STUDENTS AND PHYSICIANS

The information contained in this form will be reviewed and is accessible to the professional staff of the NCCC Wellness Center and as indicated in the statement of release. The authority to request this information is found in Section 355 of the Education Law. * _____

You will not be allowed to attend your clinical rotation until this form is complete and submitted to the Wellness Center for review. * _____

A clinical clearance form will be given to the student as proof of completion of all requirements. This form must be submitted to the appropriate Medical Assistant/ Phlebotomist faculty. * _____

If your physician identifies a health concern impacting participation in the clinical rotation, additional information may be requested from a specialist for personal and client safety purposes. * _____

I have made a copy of this physical. I understand that I am responsible for providing it to any facilities that require it.

_____

Date Signature of Student

I AM AWARE AND UNDERSTAND THAT:
(STATEMENT OF RELEASE)

In order to maintain the health and safety of their clients and meet designated health laws, agencies used for clinical and/or field placement experience may require selected information from my health record if relevant to participation in the clinical rotation. I authorize release of this required information to said agencies and to the program faculty. However, the following information is excluded:

_____

_____

_____

I understand that I may change the exclusions at any time by submitting a request in writing to the Wellness Center.

I also concur that the information contained in this form, attested to by my physician, is true.

_____

Date Signature of Student

_____

Date Witness

Please mail this form to:

Niagara County Community College
3111 Saunders Settlement Road
Sanborn, NY 14132-9460
Attn: Wellness Center,C-122

All questions may be directed to the Wellness Center at:
716-614-6275

Revised 3/20

STUDENT (Please fill out this section) Student ID # : _____

Name:_____ Date of Birth: _____
last first MI

Address:_____ Phone: _____
street city state zip code

ALLERGIES: (An allergy is a skin rash, hives, joint pain, swollen glands, stuffy nose and/or fever after exposure to something to which you are allergic.)

Do you have any allergies? ❑ No ❑ Yes If "YES", check items to which you are allergic

Environmental ❑ Medications ❑ Bee Stings ❑ Foods❑ Other ❑

Explain allergy(s) _____

Do you have a LATEX allergy? ❑ No ❑ Yes If "YES", what are your symptoms? _____

Do you have any limitations on activities that might interfere with your performance in the clinical setting? ❑ No ❑ Yes If yes, Explain:

_____

Emergency Notification

Name:_____ Relationship: _____

Home Phone: _____ Cell Phone:_____ Office Phone: _____

_____ _____
Student Signature Date

CLINICAL PLACEMENT MEDICAL CERTIFICATION/ASSESSMENT (Physician to Complete)

HEIGHT_____ WEIGHT_____ BLOOD PRESSURE_____ PULSE_____

PERSONAL MEDICAL HISTORY

Please x below if patient has had or is currently under treatment for any of the following: **(Please explain all X's marked below)**

ADD	❑	Cerebral Palsy	❑	Heart Disease/Disorder	❑	PCOS	❑
ADHD	❑	Chicken Pox	❑	Hepatitis	❑	Peptic Ulcer	❑
Alcoholism	❑	Chronic Bronchitis	❑	High Blood Pressure	❑	Seizures	❑
Anemia	❑	Colitis/Irritable Bowel	❑	Hypoglycemia	❑	Severe Cramps	❑
Anorexia	❑	Deafness	❑	Kidney Disorder	❑	Skin Disorders	❑
Anxiety	❑	Depression	❑	Learning Disability	❑	Substance Abuse	❑
Arthritis	❑	Diabetes	❑	Low Blood Pressure	❑	Thyroid Disease	❑
Asthma	❑	Emotional Disorder	❑	Mental Health	❑	Tuberculosis or TB Exposure	❑
Back/Spine Disorder	❑	Epilepsy	❑	Migraine Headaches	❑	Whooping Cough	❑
Bipolar Disorder	❑	Excessive Menstrual Flow	❑	Mononucleosis	❑	Other _____	
Bulimia	❑	Fainting Spells	❑	Multiple Sclerosis	❑	_____	
Cancer	❑	GERD	❑	Orthopedic Problems			

Explanation of boxes marked with an X:_____

_____

CHECK EACH ITEM IN PROPER COLUMN

	Normal	Abnormal	Comments
Head, Neck, Face, Scalp, Skin			
Ears, Nose & Throat			
Oral Cavity			
Lungs, Chest			
Heart			
Abdomen & Viscera			
Musculoskeletal			
Hearing			
Extremities			
Neurological			

CLINICAL PLACEMENT MEDICAL CERTIFICATION/ASSESSMENT (Physician to Complete)

Name:_____ **Date of Birth:** _____

Is there evidence of anxiety or emotional problems requiring treatment? ❑ No ❑ Yes Comments: _____

_____

Are there any physical or emotional problems to be followed while student is in college? ❑ No ❑ Yes Comments: _____

_____

Is student taking medication(s)? ❑ No ❑ Yes If so, what medication(s) _____

_____

Reason or conditions for medication_____

_____

Is this student pregnant? ❑ No ❑ Yes If yes, EDD_____ ⇢ **Note:** Attach clearance from OB/GYN Physician

Does the student have any allergies? ❑ No ❑ Yes Explain Allergy(s): _____

After considering the history and physical examination, what is your professional opinion of this applicant's ability to meet requirements of clinical rotations **with** or **without** restrictions/limitations:

- Physical demands? **1.** Capable_____ Not Capable_____ **AND**
  2. Without Restrictions_____, With the following Restrictions _____
- Emotional demands? **1.** Capable_____ Not Capable_____ **AND**
  2. Without Restrictions_____, With the following Restrictions _____

The practice of Medical Assistant/Phlebotomist involves communication with patients and direct patient care activities. Certain cognitive and psychomotor capabilities are required for the safe and skillful performance of these activities. In order to successfully progress through the Medical Assistant/Phlebotomist program a student must possess the following:

1. Visual acuity such as that needed for preparation/assistance in the administration of medications, observation and measurement of laboratory values, physical assessment activities and administrative tasks.
2. Hearing ability as that required to receive verbal messages from patients or staff members and to utilize hearing and monitoring devices such as a stethoscope. The student must be able to hear and transcribe medical dictation using conventional transcription equipment.
3. Motor skills and coordination as needed to implement the skills required to meet the needs of patients and also to operate computers and other technical equipment.
4. Communications skills such as those of speech, reading and writing as needed to interact with and interpret patient needs and communicate these as necessary to provide safe and effective care.
5. Reading, writing and cognitive skills such as those required for written examinations, research papers and the composition of medical letters and communications.
6. Mathematical skills such as those necessary for laboratory calculation.
7. Intellectual and emotional ability to coordinate patient care and manage activities within an ambulatory care facility.
8. Ability to lift a minimum of fifty (50) pounds in assisting patients with getting on and off the examination table.
9. Ability to stand unsupported for up to forty-five (45) minutes.

Upon physical examination, please be specific when noting any abnormal physical findings or anything that you feel may interfere with that person's ability to be successful in the Medical Assistant/Phlebotomist program. A consultation by a specialist in the area of concern is required when an abnormality is noted.

At the conclusion of the physical exam, please review and sign the following:

"I have performed the medical evaluation and found to the best of my knowledge, her/him to be free from physical, mental, or emotional impairments including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior altering substances which might interfere with the performance of her/his duties or would impose a potential risk to patients or personnel."

_____ _____ _____

Physician/Nurse Practitioner/PA Signature | Date | Physician/NP/PA Stamp

_____

Street Address | City | State | Zip | (Area Code) Telephone

Name:_____ **Date of Birth:** _____

The following immunizations are required by all students entering a health field regardless of age:

NOTE: REQUIRED NEW YORK STATE IMMUNIZATIONS MUST INCLUDE MONTH, DAY AND YEAR

All students must submit proof of immunity to Measles, Mumps and Rubella.

Tetanus/Diphtheria: Required every 10 years **Date**_____ Please specify Td or Tdap _____

TB Screening

1. Does the student have signs or symptoms of active TB disease: no ❑ yes ❑ If NO, proceed to question 2—If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. A history of BCG vaccination does not preclude testing of a member of a high-risk group.
   History of BCG vaccine _____ If YES, what year? _____
3. Tuberculin Skin Testing (TST)
   Date Given _____ Signature_____ MD/PA/NP/RN

   Date Read _____ Results _____mm* Signature_____MD/PA/NP/RN
   *(Record actual mm of induration, transverse diameter: if no induration, write "0".)
   Interpretation (based on mm of induration as well as risk factors): Positive ❑ Negative ❑
4. Chest x-ray (required if tuberculin skin test is positive): Date_____ Result_____
   (Copy of Report REQUIRED- Attach Report)
5. Treatment Plan if indicated:_____

Chicken Pox (Varicella) Disease History: No ❑ Yes ❑ Date_____

OR

Date of Varicella Titer_____ Results_____
(Copy of Report REQUIRED- Attach Report)

OR

Dates of Varicella Immunization (1)_____ (2)_____

Hepatitis Vaccine -- MUST CHOOSE ONE OPTION BELOW

Hepatitis B vaccination is STRONGLY recommended for all Allied Health students due to the high risk of exposure to blood or other potentially infectious materials. This risk of exposure places you at a high risk of acquiring Hepatitis B infection.

Hepatitis B Vaccine Date #1_____ Date #2_____ Date #3_____

Optional: Hepatitis B Surface Antibody Screening Date_____ Immune no ❑ yes ❑
(Copy of titer REQUIRED --Attach Report)

OR

Hepatitis Declination Statement (To Be Completed By Student If Appropriate)

I understand that due to possible exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been advised to be vaccinated with Hepatitis B vaccine; however, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

_____ _____

Student's Signature Date

_____ _____ _____

Physician/Nurse Practitioner/PA Signature Date Physician/NP/PA Stamp

_____

Street Address City State Zip (Area Code) Telephone