Name:______________________________ DOB MM/DD/YY:______________
Address:____

City:____________________ State:______ Zip Code:__________________

HAVE YOU HAD OR DO YOU HAVE:	*YES*	*NO*
Vision or Hearing problems (if yes, please explain)		
Heart Problems (if yes, please explain)		
Childhood diseases (if yes, please explain)		
Epilepsy, Diabetes, High Blood Pressure, Kidney problems (if yes, please explain)		
Bone/joint disease or injury, back injury (if yes, please explain)		
Serious Injuries/Major surgery, Hernias (if yes, please explain)		
Mental Illness/Nervous Disorder (if yes, please explain)		
Drug/Alcohol problems (if yes, please explain)		
Lung disease (if yes, please explain)		
Skin problems/diseases (if yes, please explain)		

I hereby certify that this information is true to the best of my knowledge.

______________________________ ______________

Student Signature Date

FOR PHYSICIAN USE ONLY

____

PATIENT NAME AGE HEIGHT WEIGHT

PHYSICAL EXAMINATION

DATE:____________

HEENT:______________________________ Lungs:______________________________

Heart:______________________________ **Pulse:__________ **BP:______________

Abdomen:___________________________ Extremities/Joints:_____________________

Neurologic/Mental:____

**Vision: R__________ L___________ **Corrected: R__________ L__________

(**indicates the numerical assessment must be documented)

Based on this physical, do you find any reason why this person cannot physically perform these activities?

Yes____ No____

If yes, please explain:____

Name:____MD, DO, PA, FN
(Please Print)

Signature:____

Address:____

City:______________________________

State:_________ Zip Code:_________________________

EMERGENCY MEDICAL TECHNOLOGY

IMMUNIZATION RECORD

I, ____

Print Name (last, first, MI) Signature

give permission to ____

to complete this form and release this information to Phoenix College. DATE: ____________________

****

REQUIRED:

1. Tuberculin Intermediate Skin Test (PPD): (Must be good thru March 2008)

   Date __________ Result __________

   (Optional): Chest X-Ray

   Date __________ Result __________

2. One of the following

   Rubella Titer: Date_______ Result _______

   (German Measles)

   Rubella Vaccine: Date_______

   Rubeola Titer: Date_______ Result _______

   (Measles)

   Rubeola Vaccine: Date_______

   M.M.R. Vaccine: Date_______

3. Date when you had the Chicken Pox: __________ OR

   Varicella Titer: Date_________ Result __________

   (Chicken Pox)

   Varicella Vaccine: Date____________

Phoenix College Emergency Response Programs

(602) 285-7125

4. Hepatitis B Vaccine (HBV) Series Highly Recommended, but Not Required. If you elect not to receive the HBV vaccination you must to sign the Hepatitis B Vaccination Declination Form (attached).

The HBV Series Is a 3 Step Process for Each Portion of the Vaccination

Date:______________ Date:_______________ Date:______________

5. Current Influenza Vaccination

Date:___________________________

If you Elect Not to Receive the Influenza Vaccination You Must Sign the Influenza Vaccination Declination Form (attached).

MARICOPA COMMUNITY COLLEGE DISTRICT
ALLIED HEALTH PROGRAMS

VACCINATION DECLINATION

(PRINT) Student Name________________________ Date_______________

Hepatitis B Vaccination Declination

I understand that due to my exposure to blood or other potential infectious materials during the clinical portion of my allied program, I may be at risk of acquiring Hepatitis B virus (HBV) infection. The health requirements for the allied health program in which I am enrolled, as described in the Student Handbook, include the Hepatitis B vaccination series as part of the program's requirements. I have been encouraged by the faculty to be vaccinated with Hepatitis B vaccine; however, I decline the 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. By signing this form, I agree to assume the risk of a potential exposure to Hepatitis B virus and hold the Maricopa Community College Allied Health Program as well as all health care facilities I attend as part of my clinical experiences harmless from liability in the event I contract the Hepatitis B virus.

________________________________ ______________________

Student Signature Date

MARICOPA COMMUNITY COLLEGE DISTRICT
ALLIED HEALTH PROGRAMS

VACCINATION DECLINATION

(PRINT) Student Name ______________________________ Date ___________________

Influenza Vaccination Declination

I understand that due to the nature of health care and the volume of individuals that I may come in contact with, I may be at risk of acquiring an influenza virus. The health requirements for the allied health program in which I am enrolled, as described in the Student Handbook, include the current influenza vaccination as identified by the Centers for Disease Control for the current influenza season as part of the program's requirements. I have been encouraged by the faculty to be vaccinated; however, I decline the influenza vaccination at this time, I understand that by declining this vaccine, I continue to be at risk of acquiring influenza. By signing this form, I agree to assume the risk of potential exposure to influenza and hold the Maricopa Community College Allied Health Program as well as all health care facilities I attend as part of my clinical experiences harmless from liability in the event I contract the virus. I also understand that, due to the contagious nature of the virus, that a health care setting may not accept my placement if I refuse vaccination.

______________________________________ ___________________________

Student Signature Date

This form cannot be used in CastleBranch Medical Document Manager.

DO NOT upload this document into CastleBranch or myClinicalExchange. If your program is using CastleBranch (CB) Medical Document Manager, you will need to obtain their Influenza Vaccination Declination Form from CastleBranch website or your Program Director or Clinical Coordinator. CastleBranch will require proof of Declination of Flu Immunization due to Religious Beliefs: or Declination due to Medical Contraindication: (Medical Provider to indicate reason for contraindication).