GREATER ALTOONA CAREER & TECHNOLOGY CENTER

Continuing Education Office
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Student Health Record for Participation in Clinical Experience

I. PATIENT INFORMATION – To be completed by the student.

Patient's Name: Last First MI Social Security (last 4 digits) ▪ Male ▪ Female

Mailing Address (County)

Telephone Number Date of Birth (Mo/Day/Year) Place of Birth (State/Foreign Country)

II. IMMUNIZATION RECORD – To be completed by a physician.

	Date	Date	Date
Tetanus (current within 10 years)			
Rubella (recent immunization if negative titer)			
Hepatitis B (If series greater than 10 years old need recent positive titer or booster)			

Varicella Has the student listed above had chicken pox? Yes____ No_____
If No: Has the student been vaccinated (Varivax)? Yes____ No_____
If No, provide verification of immunity:_____

If Yes, date of vaccination:_____

Mantoux test results_____ Date Administered _____ Date Read_____

If Mantoux report is positive, Chest X-Ray Results_____

Date student received flu shot _____

III. HEALTH HISTORY	Yes	No	If Yes, Explain
Allergies.....	( )	( )	_____
Arthritis.....	( )	( )	_____
Asthma.....	( )	( )	_____
Back Injuries.....	( )	( )	_____
Cardiac.....	( )	( )	_____
Chemical Dependency: Drugs/Alcohol.....	( )	( )	_____
Diabetes Mellitus.....	( )	( )	_____
Gastrointestinal Disorder.....	( )	( )	_____

Hearing Disorder.....	**( )**	**( )**	_____
Hepatitis.....	**( )**	**( )**	_____
Hernia.....	**( )**	**( )**	_____
Hypertension.....	**( )**	**( )**	_____
Neuromuscular Disorder.....	**( )**	**( )**	_____
Orthopedic Condition.....	**( )**	**( )**	_____
Respiratory Illness.....	**( )**	**( )**	_____
Seizure Disorder.....	**( )**	**( )**	_____
Skin Disorder.....	**( )**	**( )**	_____
Tuberculosis.....	**( )**	**( )**	_____
Urologic Disorder.....	**( )**	**( )**	_____

V. HISTORY OF SERIOUS ILLNESS/OPERATIONS ☐ Yes ☐ No

If Yes, explain _____

Physician Comments (to explain unusual circumstances):_____

_____

_____

A. MEDICAL ACCEPTANCE

I find her/him to be free of communicable diseases, have the necessary manual dexterity and visual acuity, and in a state of health capable of meeting all requirements necessary to function competently in the medical profession.

_____ _____ _____

Physicians' Signature **Type or Printed Name** **Date**

_____ _____

Address **Phone Number**

B. MEDICAL DENIAL OF ACCEPTANCE

Upon completion of this examination, I find that I cannot give medical clearance for the above-named student to enter your course of study. I have thoroughly discussed this with the student giving a full explanation with validated reasons for my decision along with suggested approaches to benefit her/his continued health approach.

_____ _____

Physician's Signature **Date**