# Los Angeles Mission College –Health Record Form

Take these documents to your physical exam appointment.

(This section is to be filled out by the student.)

Name (last, first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LACCD email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­**Area(s) of study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Training Program**

Circle any disease(s) below that you may have had or have:

Anemia Arthritis Asthma Allergies Chicken Pox Long Covid-19

Diabetes Heart Problems Epilepsy Cancer Kidney problem Measles

Mumps Pneumonia Polio Smallpox Thyroid Disorders Tonsillitis

Have you had any operations in the past? Please list them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? If yes, please explain! \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history (circle and note relative):

Tuberculosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Exam (This section is to be filled out by the healthcare professional.)**

|  |  |
| --- | --- |
| GENERAL APPEARANCE: | DENTAL HYGIENE: |
| HEIGHT: | THROAT: |
| WEIGHT: | ABDOMEN: |
| POSTURE: | GLANDS: |
| SKIN: | THYROID: |
| BACK: | LUNGS: |
| EYES / RETINA / PERRLA/**COLOR VISION** (MANDATORY for WFM working with point of care testing)  Pass\_\_\_\_ Fail \_\_\_\_  N/A ­­\_\_\_\_ (Job duty does not involve POC testing or electrical)­­ | HEART: |
| EARS / HEARING | PULSE: |
| NOSE: | ENDOCRINE SYSTEM Disorders: |
| BLOOD PRESSURE: | NERVOUS SYSTEM Disorders: |

**IMMUNIZATION HISTORY MANDATORY/TITER TEST + DRUG TEST**

| **Specific Test/Vaccine** | **Date(s)** | **Results** | **Examiner’s Initials** |
| --- | --- | --- | --- |
| Tuberculin Skin Test- Submit 2 skin TB tests 1-3 weeks apart,  (Note: It is recommended to do the QuantiFERON Test to avoid double skin testing). |  |  |  |
| **CXR at or after date of +TST** |  |  |  |
| Negative IGRA: QuantiFERON or Tspot (<12 months) |  |  |  |
| If Positive: **CXR (at or after date of +IGRA)** |  |  |  |
| History of Active TB with Treatment |  |  |  |
| ***If Treatment*** *for Active TB:*  *CXR (after date of completed Tx)* |  |  |  |
| History of LTBI Treatment |  |  |  |
| ***If LTBI Treatment***  *CXR (at or after date of Tx)* |  |  |  |
| Hepatitis B Surface Ab Titer (HbsAb)  anti-HBs |  | **HbcAb/** Non-reactive  **anti-HBc** Reactive  **HbsAg** Non-reactive  Reactive |  |
| **If no Hep B Vaccine documented, must vaccinate AND document either:** |  | 3 dose series  (Engerix-B or Recombivax)  **Or**  2 dose series  (Heplisav-B) | Dose 1 Date\_\_\_\_ Initial\_\_\_\_\_\_\_\_\_\_  Dose 2 Date\_\_\_\_  Initial\_\_\_\_\_\_\_\_\_\_  **AND**  Dose 3 Date\_\_\_\_  Initial\_\_\_\_\_\_\_\_\_\_  **If (Engerix-B or Recombivax)** |
| Measles (Titer/Vaccine)  If not immune, give  Vaccination x 2,  unless Rubella x 1 |  | Immune \_\_\_\_\_\_\_\_\_\_  Non-Immune\_\_\_\_\_\_\_  Equivocal\_\_\_\_\_\_\_\_\_\_  Laboratory\_\_\_\_\_\_\_\_\_  confirm of disease\_\_\_ |  |
| Mumps (Titer/Vaccine)  If not immune, give  Vaccination x 2 |  | Immune  Non-Immune  Equivocal  Laboratory  confirm of disease |  |
| Rubella (Titer/Vaccine)  If not immune, give  Vaccination x 1 |  | Immune  Non-Immune  Equivocal  Laboratory  confirm of disease |  |
| Polio (Titer/Vaccine)  If not applicable, please write not applicable (N/A) with explanation for clearance |  | Immune  Non-Immune  Equivocal  Laboratory  confirm of disease |  |
| Varicella (Chicken Pox) (Titer/Vaccine) |  | Immune  Non-Immune  Equivocal  Laboratory  confirm of disease |  |
| Diphtheria/Tetanus  (If you had the series as a child, then all you need is the booster within the last ten years). |  |  |  |
| Acellular Pertussis (Tdap) X 1 |  |  |  |
| COVID-19  (Vaccinations and boosters are required by healthcare facilities where clinical training takes place. Include record) or **if declined must wear a mask during respiratory virus season** |  |  |  |
| Flu Vaccine (when applicable) **Highly recommended** (some facilities require the vaccine) or **if declined must wear a mask during respiratory virus season** |  |  |  |
| Drug Screen  (8-panel minimum – if not available, please provide an order)  **\*Must provide the list of drugs tested with results.** |  |  |  |

If the titer is negative or does not show immunity, submit a record of receiving the vaccinations. Then, a repeat titer as designated per medical protocol. Copies of all laboratory reports are required (i.e., drug test and/or titers).

The applicant is free of conditions that will prevent participation in the clinical practice of the Training Program Y\_\_ N\_\_

Recommendations/notes by the healthcare practitioner:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Examined by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare practitioner’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_