EL CAMINO COLLEGE
Health Sciences and Athletics Division
Respiratory Care Program

Physical Exam Portion of RC application

PHYSICAL EXAMINATION FORM

HEALTH HISTORY PROFILE

NAME:_____ **PROGRAM:** _____ **DATE:**_____

ADDRESS:_____ **PHONE:**_____ **AGE:**___ **DOB:**_____

Instructions to Applicant: Complete the HEALTH HISTORY PROFILE (Page 1). Schedule an appointment with your health provider or El Camino College's Health Center for a physical examination, required laboratory tests and immunization update. Take this form to your scheduled appointment and have Page 2+3 completed by your health provider.

Please Note: Pages 2+3+4 must be completed by an authorized health professional. Pages 2+3+4 must be completed in its entirety before **submitting** this form **to** the **ECC Respiratory Care Program.**

Do you have or have you ever been treated for any of the following (explain all yes answers):

	YES	NO
1. Hearing problems	____	____
2. Wear glasses (Contacts)	____	____
3. Dental problems	____	____
4. False teeth (Bridges)	____	____
5. High blood pressure	____	____
6. Heart murmur	____	____
7. Ulcer	____	____
8. Nervous stomach	____	____
9. Gall bladder disease	____	____
10. Hemorrhoids	____	____
11. Hernia	____	____
12. Kidney/bladder infection	____	____
13. Kidney stones	____	____
14. Mononucleosis	____	____
15. Frequent sore throat	____	____
16. Appendicitis	____	____
17. Diabetes5____	____	
18. Hepatitis	____	____
19. Epilepsy	____	____
20. Frequent respiratory infection	____	____
21. Asthma	____	____
22. Anemia	____	____
23. Tuberculous	____	____
24. Tumors	____	____
25. Skin Problems	____	____
26. Cancer	____	____
27. Psychological problems	____	____
28. HIV+	____	____

Explain all yes responses:

_____
_____
_____

Are you taking any medications?
YES _____ NO____

If yes list all medications:

_____
_____
_____

Have you had any operations?
YES ___ NO ___
If yes provide a surgical history.

_____
_____
_____

Have you had any recent accidents or injuries? (e.g. back, head, etc)
YES ___ NO ___
If yes describe each accident/injury

_____
_____
_____
_____
_____

Do you have any allergies?
YES ___ NO ___
If yes, describe your allergies and how they are treated

_____

Have you ever been treated for psychological problems?
Yes ___ No ___

If yes describe:

_____
_____
_____
_____
_____
_____

My signature below indicates that all information provided is true and accurate to the best of my knowledge.

_____
STUDENT SIGNATURE

Student Name _____ Student ID #_____

LABORATORY REPORT

Ht _____ Wt _____ BP _____ Pulse _____

	NL	Comments
Eyes		_____
Ears		_____
Throat		_____
Teeth		_____
Gums		_____
Neck		_____
Chest		_____
Heart		_____
Lungs		_____
Abdomen		_____
InguinalRings		_____
Neurological		_____
Skin		_____
Genitourinary		_____
Back		_____
Extremities		_____
Pelvic(optional)		

Laboratory Test	Results
Hemoglobin	_____
Urinalysis	_____

Student Name (print) _____ Student ID #_____

IMMUNIZATION REPORT:

1. TDAAP(date)____ Tetanus Booster (date)_____ Flu (date)_____
   Proof of vaccinations must be submitted

2. Hepatitis Screening (or signed waiver) immunity____ lack of immunity_____
Vaccination* (if Hepatitis Screening indicates lack of immunity and vaccination is selected)
Date started_____
Date completed (if applicable)_____

3. Laboratory evidence of IgG Immunity levels for the following is required.
   The word "immune" on a lab slip is **NOT accepted** by some hospitals.
   Lab report **MUST** provide a numerical value and a range value with an explanation of the results.
      Rubeola(10 day measles)_____
      Rubella(3 day German measles)_____
      Mumps_____
      Varicella(chicken pox)_____

   MMR (measles, mumps, rubella) Vaccination (date)_____
   Varicella vaccination (date)_____
   (required if any of the above Titers indicates lack of immunity)

4. Please note* Influenza Vaccination will be required during influenza seasons

RECOMMENDED: RESULTS/DATE

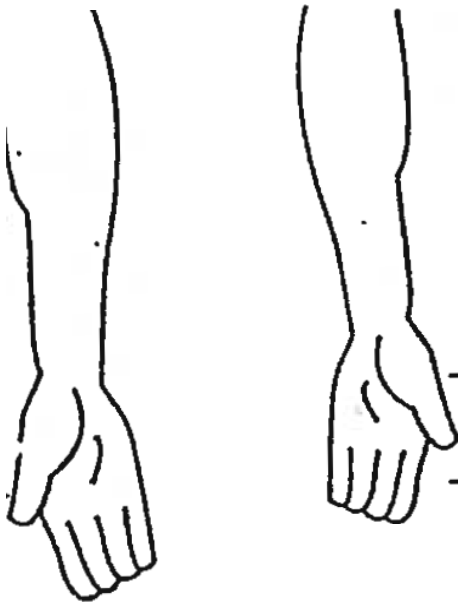
5. Polio Vaccination _____

6. HIV/AIDS _____

Student Name: _____ **student ID#:** _____

Tuberculosis Clearance

An initial documentation of a negative two step PPD is required on admission to the program. Second PPD should be administered 7-14 days after the first PPD. An annual PPD is required thereafter.



Right Arm Left Arm

Place an X on the arm above at the site where the PPD injection was administered.

Initials _____ Initials _____

Date _____ Date _____

Initial Two Step PPD # 1	Date Administered: _____ Date Read: _____	mm: _____ Signature: _____
Initial Two Step PPD # 2	Date Administered: _____ Date Read: _____	mm: _____ Signature: _____
Annual PPD	Date Administered: _____ Date Read: _____	mm: _____ Signature: _____
Positive PPD		
Initial Positive PPD	Date Administered: _____ Date Read: _____	mm: _____ Signature: _____
Chest X-ray	Date: _____ Results: _____ _	Signature: _____

Positive PPD requires documentation of date & measurement of positive PPD and a chest X-ray every year while enrolled in the program.

**** An OFFICIAL COPY of chest X-ray report must be submitted with this form.**

Student Name _____ Student ID#_____

ACTIVITY RATING:

( ) No Limitations, physically and mentally able to work as health care professional in acute care settings.
( ) Clinical/physical/mental Limitations: (please describe)

(Comments)_____
_____

Health Professional Name (PRINT)_____**Phone**_____

AFFIX OFFICIAL FACILITY STAMP BELOW
Should include facility name, address, and phone number

Signature _____ Date _____

(Physician or authorized health care professional, acknowledges you have reviewed page one as well and have checked the appropriate activity rating

EL CAMINO COLLEGE
Health Sciences and Athletics Division
Respiratory Care Program

March 22, 2023

To: **Entering Respiratory Care Clinical Students**

From: **Roy Mekaru RRT MHA**
Faculty Coordinator/Program Director

Re: **Hepatitis B vaccine declination/waiver/ Print, sign and attach is not getting Hep.B Vac.**

I understand that due to my occupational exposure as a respiratory care student to blood or other potentially infectious and hazardous materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been informed about the risk of blood borne diseases and that the Hepatitis B Vaccine is strongly recommended by health professionals and may be required by hospitals/clinics affiliating with respiratory care programs. I have also been informed about where I can receive the Hepatitis B Vaccine and the approximate cost to me.

I choose not to have the hepatitis B vaccination at this time and understand that by declining this vaccination I continue to be constantly at risk of acquiring hepatitis B when in the clinical lab setting.

Date: _____

_____
Student Signature

_____
Student name - Print

_____
El Camino College Student Identification Number