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.**

Page 1

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 (print) _____ 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)_____
   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

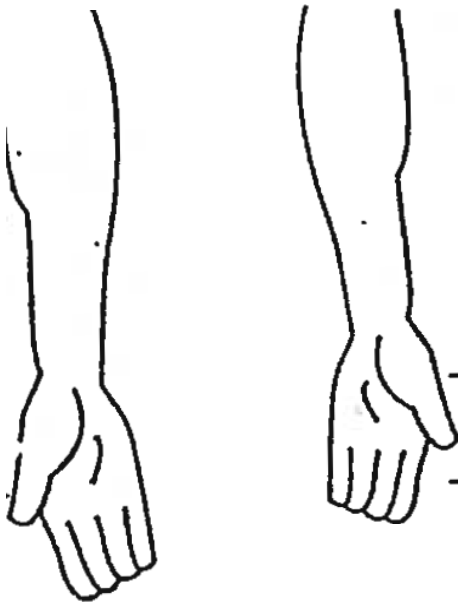
5. Polio Vaccination _____

6. HIV/AIDS _____

Student Name (PRINT): _____ **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(print)_____ 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