LORAIN COUNTY JOINT VOCATIONAL
ADULT EDUCATION
ALLIED HEALTH PROGRAM

IMMUNIZATION AND
HEALTH RECORD FORM

PART A (TO BE COMPLETED BY STUDENT) DATE:_____

NAME_____ AGE_____

ADDRESS_____ SEX_____

PHONE_____ MARITAL STATUS S M W D

PART B (TO BE COMPLETED BY PHYSICIAN)

HEIGHT_____ ALLERGIES_____

WEIGHT_____ **FUNCTIONAL ABILITIES**

TEMPERATURE_____ VISION:
RIGHT EYE _____

PULSE_____ LEFT EYE_____

RESPIRATIONS_____

BLOOD PRESSURE_____ HEARING:
RIGHT EAR _____
LEFT EAR _____

CURRENT MEDICATIONS:

_____ _____

_____ _____

_____ _____

PHYSICIAN'S SIGNATURE_____DATE_____

REQUIRED TUBERCULOSIS TESTING:

Mantoux Step One: Date Administered_____
Date Read_____By_____Results_____

Mantoux Step Two: Date Administered_____
Date Read_____By_____Results_____

If Mantoux testing is done at TB clinic, please attach copy of documentation.

RECOMMENDED IMMUNIZATION

Hepatitis B Series is **REQUIRED** for any student enrolled in any of the Allied Health Programs.

Provide documentation or have physician or nurse complete below:

Hepatitis B (series of 3) (**Signature Required**)	Initial Date (Dose 1)	One (1) Month Date (Dose 2)	Six (6) Month Date (Dose 3)

REQUIRED VERIFICATION OF VARICELLA (CHICKEN POX) DISEASE:
All students must show serological evidence of being immune to varicella or they must get the vaccine. A history of the illness is not sufficient.

A Varicella Titre is **required**. If the varicella Titre indicates a lack of immunity, Varivax vaccination is required:

Varicella Titre: Please attach IgG titer results.
Varivax Vaccination: ____/____/____ _____
Date Signature of Nurse or Physician Required

REQUIRED MEASLES, MUMPS, RUBELLA (Complete section A, or B)

A. **MMR** (Measles, Mumps, Rubella) VACCINES

#1Date____/____/____ and at least one month later
#2Date____/____/____

B. Measles (Rubeola) (a or b)

a. Two doses of live vaccine at least one month apart.
Dates#1____/____/____#2____/____/____
Or
b. Positive Titre____:_____ Date ____/____/____

Mumps (Parotitis) (a or b)

a. Live vaccine Date ____/____/____
Or
b. Positive titre____;____ Date ____/____/____

Rubella (German Measles) (a or b)

a. Live vaccine Date ____/____/____
b. Or
c. B. Positive Titre____;____ Date ____/____/____

DIPHTHERIA/TETANUS
Any combination of three or more doses of DPT, DT, or TD, provided the last dose was administered with the last ten years.
Type_____ Date of lasts dose____/____/____
Or
Positive titre:____:____ Date____/____/____

MEDICAL WAIVER
The above named student has been examined by me. In my opinion the physical condition of the student is such that his/her health will be endangered by any such immunization.

Physician or Registered Nurse

Signature_____RN/MD

PHYSICAL EXAMINATION (To be completed by Physician)

Your patient has been accepted into the Medical Assisting, STNA or Phlebotomy Program at Lorain County Joint Vocational Adult Career Center. It is important for the school to know if a student's health status would prevent safe clinical performance. If you believe laboratory tests are necessary to evaluate the overall health of the student, please do so at your own discretion.

Please answer each of the following after you have examined or treated the patient.

1. Yes No Able to meet demands (lifting, standing, etc.) of the Medical Assisting, STNA, Phlebotomy Program.

2. Yes No Is free of communicable disease

3. Yes No Is in a state of physical and mental health that would allow safe clinical practice.

4. Yes No No condition or disability exists that might interfere with the student's attendance and progress in the program.

If any statement is marked NO, please list and complete the following:

Yes No This condition is temporary- Date of Release_____

Yes No This condition is permanent.

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (Please Print) Address

_____ _____
Telephone Number City/State

NOTE: This original form will become part of the student's permanent record. Please make copies for your future use.