Miami Dade College
Medical Campus

Student Health Record Form

School of Health Sciences

Student Name: _____ **Student ID:** _____

Last **First** **Middle Initial**

I understand that student health information is protected and confidential under State of Florida and federal laws.

- I voluntarily provide, and consent to my medical provider or physician providing, the medical information contained in this document to the Miami Dade College and health care facilities that I am assigned to as part of Miami Dade College's medical program requirements.
- I also understand that all requested Student Health Record information is a prerequisite to enrollment in the clinical training of any Medical Campus program. Failure to complete this record will prevent my participation in the clinical training.
- The student and Health Care Examiner (MD, DO, PA, ARNP) must sign in the appropriate spaces provided on the form.
- All documentation for lab results must be uploaded to the Complio system hosted by American DataBank (ADB). (Drug Screening results from ADB will automatically be included in each student's Complio profile.)
- I WILL NOT submit this Student Health Record Form for any immunization requirements within Complio.

SECTION 1: PERSONAL INFORMATION

All areas of this section must be completed. This information will be kept on file and used in the event that the student must be contacted, or an emergency contact is required.

SECTION 2: REQUIRED INFLUENZA INJECTION (FLU SHOT)

Students participating in a clinical rotation must receive the influenza injection as soon as it is available and show proof to the school and the health care facility. Students that cannot participate in the influenza injection process as a result of a medical condition or refuse to participate in the influenza injection may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize the student's ability to participate in the clinical portion of a Medical Campus program. It is highly recommended that all students receive the influenza injection.

SECTION 3: REQUIRED TITERS/TESTS

A. **Varicella (Chicken Pox):** A Varicella Titer must be drawn. **A record of the Varicella Vaccine will not be accepted as documentation of the required titer.** The date of the titer and results must be indicated in the appropriate area. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

Mumps, Rubeola (Measles), and Rubella (German Measles): A Mumps, Rubeola, and Rubella Titer must be drawn. A **record of the MMR (Mumps, Measles, Rubella) Vaccine will not be accepted as documentation of the required titer.** The dates of the titers and the results must be indicated in the appropriate area. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

B. **TB Skin Test:** Two consecutive TB Skin Tests are required. The TB Skin tests can be repeated a minimum of seven days apart. The Skin Tests must have been performed within the last three (3) months to be considered a recent test. Results from QuantiFERON are acceptable within the last three (3) months.

Chest X-ray: A recent Chest x-ray is required if a positive TB skin Test or QuantiFERON is reported or there is a history of a positive TB Skin Test. The chest x-ray must have been completed within the last three (3) months to be considered current.

C. **Drug Screening:** A minimum of a **10-panel** drug screen is required through the Complio system of American DataBank. (Drug Screening results from ADB will automatically be included in each student's Complio profile.) A second drug screen test may be required by some health care facilities. ***A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Campus program at Miami Dade College.***

Section 4: Hepatitis B Vaccine

Students must provide documentation of the initiation or completion of the Hepatitis B vaccine series at the time of application. It is highly recommended that the student complete the series while enrolled in the program. Further information of the Hepatitis B Vaccine is provided on the **Student Health Record Form** on page 4.

Section 5: Tdap (Tetanus, Diphtheria, Pertussis) Vaccination

Students must provide documentation of the Tdap vaccination within the last ten (10) years.

Section 6: COVID-19 Vaccine

You must Submit either 2 doses (Pfizer, Moderna or Novavax) or single dose (Johnson & Johnson) of the COVID-19 vaccine. If you are declining the COVID-19 vaccine for medical or religious reasons, you must provide a declination letter from your healthcare provider or religious leader. ONLY medical and religious declinations will be accepted. Miami Dade College cannot guarantee clinical placement if a student or faculty member chooses not to follow our clinical affiliates COVID-19 protocol.

Section 7: Student's Statement

Student must read and sign this statement on page 4 of the Student Health Record.

Section 8: Examiner's Statement

The Health Care Examiner (MD, DO, PA, and ARNP) must read, sign, and confirm that the student can meet the Physical Demands associated with the program in the Examiner's Statement Area on page 5 of the Student Heath Record.

Student Name: _____ **Student ID:** _____
Last First Middle Initial

Please Place Health Care Provider Office Stamp or Attach Business Card Here (Required):

SECTION 1: PERSONAL INFORMATION

_____ Apt.#_____ _____
Address E-mail address
_____ _____ _____ Gender: M ____ F ____
City State Zip Code
_____ / _____ / _____ _____ _____
Date of Birth Home Telephone Number Cellular Phone Number
_____ _____ _____
Person to Notify in Emergency Relationship Contact Telephone Number

SECTION 2: INFLUENZA INJECTION

Date of injection: _____

I understand that if I cannot participate in the influenza injection process as a result of a medical condition or refuse to participate in the influenza injection, I may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize my ability to participate in the clinical portion of a Medical Campus program.

STUDENT SIGNATURE: _____ **DATE:** _____

SECTION 3: REQUIRED TITERS/TESTS

Parts A, B, C: THESE BOXES ARE TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL ONLY

A. REQUIRED TITERS:

A Varicella (Chickenpox), Mumps, Rubeola (Measles), and Rubella (German Measles) Titer must be drawn. ***A record of Vaccines WILL NOT BE ACCEPTED as documentation for the required titers.*** The dates of the titers and the results must be indicated in the appropriate area below. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

TITER	DATE	LAB RESULTS (Numerical Value of Results Must Be Reported Below)	Please Circle
Varicella (Chickenpox) Titer	____/____/____ Month Day Year		**Immune/ Not Immune**
Mumps Titer	____/____/____ Month Day Year		**Immune/ Not Immune**
Rubeola (Measles) Titer	____/____/____ Month Day Year		**Immune/ Not Immune**
Rubella (German Measles) Titer	____/____/____ Month Day Year		**Immune/ Not Immune**

Student Name: _____ **Student ID:** _____
Last First Middle Initial

B. TB SKIN TEST/ QUANTIFERON /CHEST X-RAY

Two consecutive TB Skin Tests are required. ***The TB Skin tests can be repeated a minimum of seven days apart***. *T*he Skin Tests must have been performed ***within the last three (3) months*** to be considered a recent test. Results from QuantiFERON are acceptable. **In the event the results indicate a positive skin test or QuantiFERON, or the student has a history of a positive TB skin test, a chest x-ray is required. The chest x-ray must have been completed within the last three (3) months to be considered current.**

TEST	DATE	RESULTS	
TB Skin Test **1st Test**	____/____/____ Month Day Year	**Positive _____ Negative_____**	**If positive skin test, current chest x-ray is required.**
TB Skin Test **2nd Test**	____/____/____ Month Day Year	**Positive _____ Negative_____**	**If positive skin test, current chest x-ray is required.**
QuantiFERON	____/____/____ Month Day Year	**Positive _____ Negative_____**	**If positive, current chest x-ray is required.**
Chest X-ray	____/____/____ Month Day Year	**Positive _____ Negative_____**	

C. DRUG SCREENING

A minimum of a **10-panel** drug screen is required through the Complio system of American DataBank. (Drug Screening results from ADB will automatically be included in each student's Complio profile.) A second drug screen test may be required by some health care facilities. ***A positive result on this test will result in the student's inability to participate in the clinical portion of any Medical Campus program at Miami Dade College.***

TEST	DATE	RESULTS	
Drug Screen **(10 Panel)**	____/____/____ Month Day Year	**Positive _____** **Negative_____**	**Drug Screen results from ADB will automatically be added to each students' drug screen category within Complio.**

Student Name: _____ **Student ID:** _____
Last First Middle Initial

SECTION 4: HEPATITIS

Introduction: Health care professionals are at risk of exposure to blood and body fluids contaminated with the viruses that cause HIV and Hepatitis. Consistent use of Standard Precautions is the best-known means to avoid transmission of these viruses or other contaminants. Students will be taught Standard Precautions before they provide care to any patient in the clinical setting. Although it is rare, a health care worker may become exposed to one of these viruses through accidental transmission. Currently, there is no vaccine that protects against the HIV virus. However, the Hepatitis B vaccine is an effective means of preventing Hepatitis B. As a student who will be providing direct patient care, you should discuss this vaccine with your health care provider.

About the Vaccine: The Hepatitis B Vaccine is a genetically engineered "yeast" derived vaccine. It is administered in the deltoid muscle (arm) in a series of three doses over a six-month period. You should seek additional information about the vaccine from your health care provider; especially if you have an allergy to yeast or may be pregnant or are a nursing mother.

I have initiated the Hepatitis B Vaccine Series with my first dose listed below:

1st Dose: Date: ____/____/____ 2nd Dose: ____/____/____ (One month after 1st dose) 3rd Dose: ____/____/____ (Six months after 1st dose)

OR

I have already completed a Hepatitis B Vaccine Program with dates of injections listed below:

1st Dose: Date: ____/____/____ 2nd Dose: ____/____/____ (One month after 1st dose) 3rd Dose: ____/____/____ (Six months after 1st dose)

OR

I have already completed a Heplisav Vaccine Program with dates of injections listed below:

1st Dose: Date: ____/____/____ 2nd Dose: ____/____/____ (One month after 1st dose)

OR

Antibody testing has revealed that I have immunity to Hepatitis B. Yes _____ No _____

SECTION 5: Tdap (Tetanus, Diphtheria, Pertussis) Vaccination

Students must provide documentation of the Tdap vaccination within the last ten (10) years.

DATE
____/____/____ Month Day Year

Student Name: _____ **Student ID:** _____
Last First Middle Initial

Section 6: COVID-19 Vaccine

You must Submit either 2 doses (Pfizer, Moderna or Novavax) or single dose (Johnson & Johnson) of the COVID-19 vaccine. If you are declining the COVID-19 vaccine for medical or religious reasons, you must provide a declination letter from your healthcare provider or religious leader.

DATE	Manufacturer
____/____/____ Month Day Year	
____/____/____ Month Day Year	

SECTION 7: STUDENT'S STATEMENT

In order to satisfy medical program requirements, I hereby consent to the release and disclosure of my personal health information provided on the **Student Health Record Form** to Miami Dade College and any health care facility in which I am assigned for on-site clinical training. I understand that my personal health information is required to facilitate my participation in the clinical training, which is required for program completion. I also hereby release and hold harmless Miami Dade College and receiving health care facilities from any claim of violation of HIPAA or any other medical privacy rights that may arise for the release of my personal health information provided in the **Student Health Record Form**.

Print Name: _____

Student Signature:_____ Date:_____

Student Name: _____ **Student ID:** _____
Last First Middle Initial

PHYSICAL DEMANDS

In order to fulfill the requirements of the Diagnostic Medical Sonography Program, students must be able to meet the physical demands associated with the profession. Examples of these requirements include but are not limited to the following:

Code: F = frequently O = Occasionally NA = Not Applicable

Physical Demands	Code	Comments
Standing	**F**	Standing /walking for long periods of time in patient areas and during equipment operation. Sitting for extended periods of time when displaying and recording images. Moving equipment and patients weighing 125 pounds or more from wheelchair and stretchers. Pushing wheelchairs and stretchers from waiting area to procedure rooms
Walking	**F**	
Sitting	**F**	
Lifting (up to 125 pounds)	**F**	
Carrying	**F**	
Pushing	**F**	
Pulling	**F**	
Balancing	**O**	Reaching to adjust the machine or stretcher, or to assist in moving patient to and from procedure table.
Climbing	**N/A**	
Crouching	**F**	
Crawling	**N/A**	
Stooping	**F**	
Kneeling	**F**	
Reaching	**F**	
Manual Dexterity	**F**	
Feeling	**F**	
Talking	**F**	Effectively communicate using the English language in both written and oral form. Follow oral directions. Observe patients at a distance and up close. Listen to patient answer to health related questions Hear low audible sounds from both equipment and patients. Distinguish varying shades of gray and other color shades.
Hearing	**F**	
Seeing	**F**	
Communicating	**F**	

(For specific Performance Standards associated with the Diagnostic Medical Sonography Program please contact the Program Coordinator, Ms. Dailenis Diaz, at 305-237-4205.)

Limitations: _____
_____

SECTION 8: EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this document and that the information about the test results is correct. This individual can participate in all activities required to provide health care to patients in an acute or chronic care facility, emergency setting or any other situation that is part of the learning experiences in the designated health care program. The student is able to meet THE PHYSICAL DEMANDS that are listed above. (**List any limitations associated with this student in the area provided**).

_____ _____
MD/DO/PA/ARNP Signature Date

_____ _____
Office Telephone Number License Number