



Houston Community College

EMERGENCY MEDICAL SERVICES PROGRAM

555 COMMUNITY COLLEGE DRIVE
HOUSTON, TEXAS 77013

PHYSICIAN STATEMENT OF HEALTH FORM

Check appropriate box in which student is to be enrolled.

- | | | |
|---|---|--|
| <input type="checkbox"/> Associate Degree Nursing | <input type="checkbox"/> Medical Laboratory Technician | <input type="checkbox"/> Surgical Technology |
| <input type="checkbox"/> Cardiovascular Technology | <input type="checkbox"/> Respiratory Therapist | <input type="checkbox"/> Vocational Nursing |
| <input type="checkbox"/> Computed Tomography | <input type="checkbox"/> Nuclear Medicine Technology | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental Assisting | <input type="checkbox"/> Nurse Aide | |
| <input type="checkbox"/> Diagnostic Medical Sonography | <input type="checkbox"/> Occupational Therapy Assistant | |
| <input checked="" type="checkbox"/> Emergency Medical Services | <input type="checkbox"/> Pharmacy Technician(Specify) | |
| <input type="checkbox"/> Health Information Technology | <input type="checkbox"/> Physical Therapist Assistant | |
| <input type="checkbox"/> Histologic Technician | <input type="checkbox"/> Radiography | |
| <input type="checkbox"/> Medical Assistant | | |

1. NAME: _____
Last First Middle Initial

2. HOME ADDRESS _____

3. SOCIAL SECURITY (last 4 digits) _____ 4. HOME PHONE: () _____

5. DATE OF BIRTH: _____ 6. AGE: _____

7. HEIGHT: _____ 8. WEIGHT: _____ 9. TEMPERATURE _____

10. PAST HISTORY (Must be completed with dates of illnesses, operations, and injuries):

11. EYES: Vision (R) _____ (L) _____ Glasses (R) _____, (L) _____

12. EARS: Condition(R) _____ (L) _____ Hearing (R) _____, (L) _____

13. TEETH: _____ 14. TONSILS: _____ 15. NOSE _____

16. SINUSES: _____ 17. SKIN: _____ 18. THYROID: _____

19. POSTURE: _____ 20. HEART: _____ 21. ABDOMEN: _____

22. VARICOSE VEINS: _____ 23. ORTHOPEDIC CONDITION: _____ 24. HERNIA _____

25. BLOOD PRESSURE: S _____ D _____ 26. LUNGS: _____

27. COLOR BLINDNESS: _____ 28. FEET: (R) _____ (L) _____

29. TB SKIN TEST: (Mantoux or PPD): (Within last 6 months)

NOTE: Students with a history of BCG vaccination or those with previous positive reactions should have a current chest x-ray verifying inactive disease.

DATE OF SKIN TEST: _____ FINDINGS: _____

DATE OF CXR: _____ FINDINGS: _____

IMMUNIZATIONS

MONTH/DAY/YEAR

REQUIREMENTS

30. TETANUS (Td)

A Booster within the last 10 years

31. MEASLES, MUMPS

1ST _____

Students born on or after 1/1/57 must show proof of 2 doses.

2nd _____

Students born before 1/1/57 must Have 1 dose and show proof of Immunity to measles, mumps, Rubella (physician validated Hx, or serologic confirmation.

32. HEPATITIS B (HBV)

1ST _____

All students must receive a Complete series of Hepatitis B Vaccine or show serologic Confirmation of immunity to Hepatitis B virus (Not required for Pharmacy Tech)

2nd _____

3rd _____

Titer _____

33. CHICKENPOX HISTORY

Two doses of Varicella Zoster vaccine Must be administered to students not previously vaccinated who lack a reliable history of chickenpox.

34. SUBSTANCE ABUSE PANEL (7-10) URINE DRUG ANALYSIS WITH CREATININE AND PH LEVELS

_____ (Please attach original results.)

Date

35. PHYSICIAN FINDINGS: _____

36. PHYSICIAN RECOMMENDATIONS: _____

37. In your opinion, is this individual in suitable physical and mental condition for training in the above selected Health Science Program? _____

If not, why? _____

PLEASE RETURN THIS COMPLETED FORM TO THE PROGRAM DEPARTMENT CHAIR

*Signature of Examining Physician: _____ Date _____

Printed Name: _____

Address: _____
Street City State Zip

Phone Number: () _____

*Physician signature verified by office stamp name and / or location.

Rev. 11/30/09 /dad