



LYNCHBURG COLLEGE

DOCTOR of PHYSICAL THERAPY

All DPT students need to complete the Health Information Form and return the form to Health Services (Lynchburg College, Attn: Health Services, 1501 Lakeside Drive, Lynchburg VA 24501) by **May 6, 2011**.

Please note that all Tuberculosis (TB) screenings will be provided on site by the LC DPT program.

- If you have ever had a positive TB test result you need to complete Addendum A of this form.
- If you have a positive test result please attach a copy of the positive test result and the chest X-rays.
- If you have never had a positive test result for TB please leave Addendum A & B blank.



For Office Use Only

I__	C__
E__	E__

Clinical Clearance Form LYNCHBURG COLLEGE IN VIRGINIA

This form is ***required*** for all students interested in pursuing clinical laboratory experience as an academic course with Lynchburg College. Please carefully complete the form, providing accurate and honest information. This information will be used ***only*** by Student Health Services and will not be released without your written consent. (see box on page 4*)

Complete Part A (pages 1 and 2). Then take the ENTIRE form to your examining physician for completion of Parts B & C.

RETURN ENTIRE FORM to Lynchburg College Student Health Services, 1501 Lakeside Drive, Lynchburg, VA 24501, by one month prior to your first semester of your planned clinical lab.

PART A MEDICAL HISTORY

Last Name (please print)	First Name	Middle Name	Social Security Number
Home Address (number & street)	City or Town	State	Zip Code
BIRTHDATE: Month _____ Day _____ Year _____	Sex: Male <input type="checkbox"/>	Female <input type="checkbox"/>	Marital Status _____
Whom to notify in case of emergency	Home Phone Number	Business Phone	
Name of Primary Care Provider	Address	Phone Number	

INSURANCE

All students are *strongly* advised to have health insurance coverage while attending Lynchburg College. The College cannot protect students from the consequences of being uninsured.

Insurance Company	ID/Group#	Individual/Employee ID#
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MEDICAL CONDITIONS

List all major medical conditions, surgeries, and hospitalizations. Give brief details, including dates.

MEDICATIONS

If you take any medications orally or by injection on a frequent or regular basis, list and indicate dosage and frequency.

ALLERGIES

Do you have any allergies to medications? ___ Yes ___ No Specify _____

Other Allergies _____

PART A MEDICAL HISTORY (continued)

PERSONAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe Anxiety/Depression | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Irritable Bowel/Spastic Colon |
| <input type="checkbox"/> Asthma/Bronchitis/Pneumonia | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Frequent Colds/Sinus Infections | <input type="checkbox"/> Sexual Assault/Abuse | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Dizzy/Fainting Spells |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Anemia/Bleeding Trait |
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Epilepsy/Seizure Disorder |
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Back/Joint Injuries | <input type="checkbox"/> Chronic Headaches/Migraines |
| <input type="checkbox"/> Pelvic Infections/STD's | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> MRSA Infection | <input type="checkbox"/> Recurrent Bladder/Kidney Problem | <input type="checkbox"/> Other |

Details of above: _____

1. Do you have a physical disability? _____ If yes, explain any special services needed" _____
2. Have you ever had a serious illness, injury or operation not listed above? _____ Explain _____
3. Have you ever had an overnight hospital admission? _____ If yes, give date and reason _____

FAMILY HEALTH HISTORY

INDICATE ANY PRESENT OR PAST HEALTH CONDITIONS IN PARENTS OR SIBLINGS:

<u>ILLNESS</u>	<u>FAMILY MEMBER</u>	<u>ILLNESS</u>	<u>FAMILY MEMBER</u>
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Seizure/Neurological Disorder	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Anxiety/Depression	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Alcohol/Drug Problems	_____

Is anyone in your family or household suffering from other serious health problems? _____ If so,
Please Explain _____

PERMISSION FOR TREATMENT: THIS FORM MUST BE SIGNED AND DATED BY THE STUDENT.
If the student is a minor (under 18 years of age), this form must also be signed by a parent or legal guardian.

I certify that the information I have provided on this form is truthful, accurate and complete to the best of my knowledge. I understand it is intended for and will be used only by Lynchburg College Student Health Services personnel and will be maintained as confidential information in my student health record. This information will not be released without my written consent, *except in cases of life threatening emergencies*. If I desire assistance or accommodations from non-medical offices at Lynchburg College, I understand that it is my responsibility to contact Student Support Services at (434) 544-8419.*

Signature of Student (required) _____ Date _____

PART B IMMUNIZATION RECORD

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

REQUIRED IMMUNIZATIONS

A. MMR (Measles, Mumps, Rubella) * Dose #1 _____/_____/_____
Two doses live vaccine at or after 12 months of age, at least one month apart,
if born in or after January 1957 OR positive titers to each Rubeola/Mumps/Rubella. Mo. Day Yr

Dose #2 _____/_____/_____

Mo. Day Yr

B. TETANUS/DIPHTHERIA (Td/Tdap) BOOSTER (within last 10 years) _____/_____/_____
Mo. Day Yr.

C. HEPATITIS B Series of three vaccines OR a positive Hepatitis B surface antibody * Dose #1 _____/_____/_____
Mo Day Yr

Dose #2 _____/_____/_____

Mo Day Yr

Dose #3 _____/_____/_____

Mo Day Yr

D. VARICELLA History of Disease Year of Disease _____
OR

Varicella Vaccines Dose #1 _____/_____/_____
(2 doses at least one month apart, if over age 13) Mo Day Yr

Dose #2 _____/_____/_____

Mo Day Yr

***POSITIVE BLOOD TITERS MUST BE SUBMITTED AS PROOF OF DISEASE IMMUNITY
 IF VACCINATION DATES ARE UNAVAILABLE**

E. MENINGOCOCCAL VACCINE (optional but highly recommended dated after 16 years of age) _____/_____/_____
Mo Day Yr

F. TUBERCULOSIS SCREENING: Must complete one of the attached Addendums per CDC Guidelines.

Has pt. had a baseline TB screening for Lynchburg College setting using the 2-step tuberculosis skin tests?

If NO- complete -Addendum A. *Baseline screen is required within 6 months prior to first LC clinical lab rotation.*

If YES- complete -Addendum B (example: rising junior nursing students)

If ever a positive PPD: Attach a copy of that documentation plus the report of a chest x-ray for LC health files.

Transcribed records of student Gave vaccine to student

➡ **Health Care Provider's Signature** _____
Name Printed _____
Address _____
Phone _____

PART C PRIMARY CARE PROVIDER'S HEALTH EVALUATION

TO BE COMPLETED, SIGNED AND DATED BY EXAMINING PHYSICIAN, NP, or PA

Note to examiner: Please review the student's medical history (Part A) and complete this form, commenting on all positive answers. This information will be used as a background for providing appropriate health care and is solely for use by Lynchburg College Student Health Services. No information will be released without the student's written consent.

Date of Examination _____

Pulse _____ Blood Pressure _____ Height (in) _____ Weight (lbs) _____ Date last Td/Tdap _____

Urinalysis _____ CXR if History of positive PPD, copy of the report is required. (See page 3)

PHYSICAL EXAMINATION

HEENT	
RESPIRATORY	
CARDIOVASCULAR	
GENITOURINARY	
GASTROINTESTINAL	
MUSCULOSKELETAL	
METABOLIC/ENDOCRINE	
NEUROLOGICAL	
SKIN	

****PLEASE ATTACH ANY PERTINENT RECORDS (special tests, labs, etc.)**

Has the student ever been treated for an emotional, behavioral, or psychological condition (including eating disorders and/or substance abuse)? ___ No ___ Yes ****Explain** _____

Is the student currently under treatment for any medical/psychological condition? ___ No ___ Yes ****Explain, including recommendations for Student Health Services' follow-up** _____

Has the student ever been diagnosed with MRSA? ___ No ___ Yes/Date _____ Specific Tx _____

List any medications the student is taking. _____

➔RECOMMENDATION FOR PHYSICAL ACTIVITY/CLINICAL HEALTH CARE ASSIGNMENTS:

UNRESTRICTED ACTIVITY _____
 RESTRICTED ACTIVITY _____ ****Explain restrictions** _____

DATE _____
MD/NP/PA SIGNATURE _____
PRINTED LAST NAME _____
ADDRESS _____
PHONE _____ FAX _____

****attach letter as needed**

*RETURN COMPLETED FORM TO
 STUDENT HEALTH SERVICES
 LYNCHBURG COLLEGE
 1501 LAKESIDE DRIVE
 LYNCHBURG, VA 24501
 FAX: 434-544-8185*

FOR STUDENTS ONLY

I hereby give permission to Student Health Services to release, upon request, a copy of this Clinical Clearance Form to the Lynchburg College Clinical Program Director and/or Academic Coordinator of Clinical Education.

Student's Signature _____ Date _____

ADDENDUM-A

Baseline Tuberculosis (TB) Screening with Lynchburg College (new setting) for Health Care Workers(HCW)/Clinical Students**

HCW/Clinical Student (Pt) NAME _____ DOB _____

A. Has Pt ever had a positive reaction to a TB skin test? (circle) No Yes*
*If 'Yes' to A, documentation of (+) reading and CXR with any treatments is required for LC files.
Repeat CXR if annual screening has 'yes' to any sign or symptoms. **

B. Does Pt have any of the following signs or symptoms of active TB disease? (circle)
Fatigue No Yes
Unexplained weight loss No Yes
Loss of appetite No Yes
Night sweats No Yes
Chronic cough No Yes
Coughing up blood No Yes
Chest pain No Yes

C. Do any of these high-risk categories apply to Pt? (circle)
Plan to enter health care profession --- Yes
Known exposure to HIV infection No Yes
Recent contact with someone infected with TB No Yes
History of illicit drug use No Yes
Resided or worked in homeless shelter, prison, nursing home, hospital, or other health care facility No Yes
History of silicosis, diabetes, renal disease, blood disorders or cancer No Yes
Low body weight No Yes
Gastric bypass No Yes
Prolonged corticosteroid or other immunosuppressive therapy No Yes
Within the past 5 years traveled to or lived in any country where TB is endemic (e.g., Africa, Asia, Eastern Europe, or Central or South America) No Yes

Below is for SHS office use only:

Above completed by: _____

If "NO" to A & "Yes" to any in B-C: 2 step TST for this new setting to be administered by College SHS:

Step 1: Tuberculin Skin Test (TST)

PPD (Mantoux) 0.1 ml (5TU) intradermally left/right forearm

Lot. # _____ Exp. Date _____

Date administered ____/____/____ placed by _____ RN

Date read ____/____/____
Result _____ mm of induration Negative _____ *Positive _____ read by _____ RN

Step 2: Tuberculin Skin Test- 1-3 weeks after step 1

PPD (Mantoux) 0.1 ml (5TU) intradermally left/right forearm

Lot # _____ Exp. Date _____

Date administered ____/____/____ placed by _____ RN

Date read ____/____/____
Result _____ mm of induration Negative _____ *Positive _____ read by _____ RN

CXR required if interpretation is ever Positive

**Source: CDC. Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings. MMWR 2005; 54(RR17); 1-141.

ADDENDUM- B

Annual Tuberculosis (TB) Screening
for Health Care Workers(HCW)/Clinical Students for Lynchburg College (Setting)

DATE of SCREENING: _____ to be done 6-12 months *after baseline* TB Screening [-Addendum A] and repeated annually while a HCW/Clinical Student for this setting.

HCW/Clinical Student (Pt) NAME _____ **DOB** _____

A.. Has Pt ever had a positive reaction to a TB skin test? (circle) No Yes*
If 'Yes', documentation of (+) reading and CXR with any treatments required for LC baseline.*
Repeat CXR only if annual screening has "yes" to any sign or symptoms. **

B. Does Pt have any of the following signs or symptoms of active TB disease? (circle)

Fatigue	No	Yes
Unexplained weight loss	No	Yes
Loss of appetite	No	Yes
Night sweats	No	Yes
Chronic cough	No	Yes
Coughing up blood	No	Yes
Chest pain	No	Yes

C. Do any of these high-risk categories apply to Pt? (circle)

Plan to enter health care profession	---	Yes
Known exposure to HIV infection	No	Yes
Recent contact with someone infected with TB	No	Yes
History of illicit drug use	No	Yes
Resided or worked in homeless shelter, prison, nursing home, hospital, or other health care facility	No	Yes
History of silicosis, diabetes, renal disease, blood disorders or cancer	No	Yes
Low body weight	No	Yes
Gastric bypass	No	Yes
Prolonged corticosteroid or other immunosuppressive therapy	No	Yes
Within the past 5 years traveled to or lived in any country where TB is endemic (e.g., Africa, Asia, Eastern Europe, or Central or South America)	No	Yes

D. Has the Pt done the baseline 2-step TST for the Lynchburg College setting? (circle) No Yes
If unknown or 'No' to D, STOP HERE, do -Addendum A.

Above completed by: _____

If 'No' to A & 'Yes' to any B or C and D- the annual TST is indicated:

Annual: Tuberculin Skin Test

PPD (Mantoux) 0.1 ml (5TU) intradermally left/right forearm

Lot. # _____ Exp. Date _____

Date administered ____/____/____ placed by _____ RN

Date read ____/____/____
Result _____ mm of induration Negative _____ *Positive _____ read by _____ RN

CXR required if interpretation is ever Positive

**Source: CDC. Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health Care Settings. MMWR 2005; 54(RR17); 1-141.