****ALL INFORMATION MUST BE FILLED IN OR THIS FORM WILL NOT BE ACCEPTED! ****
(PLEASE MAKE A COPY FOR YOUR RECORDS BEFORE TURNING IN)
ILLINOIS VALLEY COMMUNITY COLLEGE – *Medical Assisting Program*

HEALTH INFORMATION FORM
MA Student

NOTE: Physical forms **Must** be completed and return to your clinical instructor.

NAME: _____ _____ _____
Last First Middle

ADDRESS: _____ _____ _____
Street City Zip

HOME PHONE: _____ CELL PHONE: _____

MARITAL STATUS: _____ SEX: _____ BIRTHDATE: _____ AGE: _____

In Case of Emergency, Please Call:

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE _____

PHYSICIAN: _____ OFFICE PHONE: _____

ADDRESS: _____ _____ _____
Street City Zip

DATE: _____

**** Student is responsible for payment of services ****

Student Name: _____

TO THE DOCTOR: This individual is an applicant for the Illinois Valley Community College CMA Program. The following health information is essential.

PHYSICAL EXAMINATION

Health History

Condition:	No	Yes	Treatment
Asthma	____	____	_____
Convulsions	____	____	_____
Diabetes	____	____	_____
Epilepsy/Seizure Disorder	____	____	_____
Allergies/Sensitivities	____	____	_____
Mental/Emotional Illness	____	____	_____
Physical Impairments	____	____	_____
Other _____	____	____	_____

Physical Status (General)	Normal	Explanation of Abnormality
Lung	_____	_____
Heart	_____	_____
Abdomen	_____	_____
Circulation	_____	_____
Skin (active/persistent conditions)	_____	_____

Physical Status (Specific)

VISION:

Requirements: Vision is required to prepare and analyze data. Using measuring devices, assembly of small parts, visual inspection, and normal color perception are also requirements.

Can be corrected to 20/40 _____

Vision Meets Requirements _____

Explanation of Abnormality _____

_____

_____

_____

Student Name: _____

Hearing:

Requirements: Must perceive forced whispered voice greater than or equal to 5 ft with or without hearing aid.
Hearing meets requirements _____
Corrective devices used _____ **Type** _____
Explanation of abnormality _____
_____

Typical Physical Demands:

Requirements: Requires full range of body motion, including manual and finger dexterity with eye/hand coordination. Frequent walking, bending, sitting, and standing for extended periods of time. Physical mode for the clinical site is medium work. That is, exerting/lifting up to 35 pounds of force **occasionally**, and/or up to 20 pounds of force **frequently**, and/or up to 10 pounds of force **constantly** to move objects.

The previous requirements include an assessment of the:

	Normal
Neck	_____
Bones/Joints	_____
Reflexes	_____
Spine	_____

Meets physical requirements stated above: _____
Explanations of abnormality: _____
_____
_____

Is this individual under any medical treatment? No _____ Yes _____

If yes, please explain:

Medications: Name: _____ _____

How often: _____

_____ This individual is physically able to function as a student in the CMA Program.

_____ This individual has **RESTRICTIONS (see note below)**

Please indicate restrictions: _____
_____
_____

Physician's Signature: _____

Date: _____

Physician's printed Name: _____

Student: I hereby acknowledge the information that I have provided in this form, which I have given to my healthcare provider is accurate.

Student Signature _____
Student Name: _____

Immunization / Testing Requirements

ONE STEP T.B. SKIN TEST:
Date: _____ Result: _____ Signature: _____

TWO STEP T.B. TEST:
Date: _____ Result: _____ Signature: _____

Date: _____ Result: _____ Signature: _____

If positive test, please indicate:

- Evaluation to rule out active disease: Date: _____ Initial: _____
- Education regarding signs, symptoms, treatment of active disease: Date: _____ Initial: _____

TDaP Immunization: Date: _____ (Within the last 10 years) Signature: _____
*** Must have the Pertussis Component ***

Note regarding MMR, Varicella, & Hepatitis B:

If you can't provide acceptable documentation you must receive the vaccinations or the titer/serological test listed below.

MEASLES, MUMPS, RUBELLA VACCINE

Dose 1: _____ Signature: _____

Dose 2: _____ Signature: _____

Laboratory Evidence Of:

Rubella Titer: Date: _____ Signature: _____

Measles Titer: Date: _____ Signature: _____

Mumps Titer: Date: _____ Signature: _____

VARICELLA

Dose 1: _____ Signature: _____

Dose 2: _____ Signature: _____

Titer Date: _____

HEPATITIS B VACCINE:

Series 1: Date: _____ Signature: _____

Series 2: Date: _____ Signature: _____

Series 3: Date: _____ Signature: _____

Titer Date: _____

All laboratory documentation should accompany physical form.

Dates & signatures must accompany all verifications of immunization(s).