ALLEGANY COLLEGE of MARYLAND
NURSE MANAGED WELLNESS CLINIC

PHONE: 301-784-5670
FAX: 301-784-5093
acmnmwc@allegany.edu
www.allegany.edu/nmwc

HEALTH CAREERS MEDICAL HEALTH EXAMINATIONS RECORD
CONFIDENTIAL
STUDENT HEALTH PROFILE

PART I: TO BE COMPLETED BY STUDENT

Name (Last, First, MI)	DOB	Gender ID ❑ M ❑ F ❑ Other
Address (include city, state and zip)	Telephone (area code & number)	
	Student ID#	
Emergency Contact	Telephone Number	Relationship
Personal Physician (include address)		Telephone
Program Applying To:		

PART II: STUDENT PERSONAL HEALTH HISTORY *(STUDENT – Please PRINT and fill out completely in INK)*

PERSONAL HEALTH HISTORY: Check below all of the following which have applied either NOW OR IN THE PAST. Please check each item. If yes, please explain below (if additional space is needed, please attach separate sheet of paper).

Yes	No		Yes	No	
❑	❑	Chicken Pox	❑	❑	Heart disease
❑	❑	Measles	❑	❑	Heart murmur
❑	❑	Mononucleosis	❑	❑	Asthma
❑	❑	Typhoid fever	❑	❑	Hay fever
❑	❑	Kidney disease	❑	❑	Back problems
❑	❑	Diabetes	❑	❑	Orthopedic problems
❑	❑	Poliomyelitis	❑	❑	Cancer
❑	❑	Rheumatic fever	❑	❑	Ulcer
❑	❑	Tuberculosis	❑	❑	Arthritis
❑	❑	Hypoglycemia	❑	❑	Epilepsy or convulsions
❑	❑	Jaundice	❑	❑	Chronic bronchitis
❑	❑	Hepatitis	❑	❑	Migraine headaches
❑	❑	Frequent sore throats	❑	❑	Skin disease
❑	❑	Ear infections	❑	❑	Sexually transmitted diseases
❑	❑	Hearing problems			
❑	❑	Visual problems	❑	❑	Surgeries
❑	❑	Thyroid dysfunctions	❑	❑	Hospitalization
❑	❑	Bleeding tendency			If yes, please explain:
❑	❑	Chest pain			
❑	❑	Shortness of breath			
❑	❑	High blood pressure			

FAMILY MEDICAL HISTORY:

CHECK EACH ITEM BELOW YES OR NO.
ANY ITEMS CHECKED YES MUST BE EXPLAINED BELOW.

Yes	No	
❑	❑	Allergies (include all known drug allergies)
❑	❑	Sensitivity to chemicals, dust, latex, etc.
❑	❑	Inability to perform certain motions.
❑	❑	Physical work limitations
❑	❑	Are you currently taking any medication, including Over the counter medications? Please list all:
❑	❑	Are you currently using any substance (tobacco, alcohol, or any other drugs)?

I hereby grant the Nurse Management Wellness Clinic permission to share medical healthcare records with the health profession programs and clinical agencies as required by the program of study.

I hereby acknowledge that the information on the Student Personal Health History form is true and complete to the best of my knowledge and nothing has been omitted which would interfere with academic and technical standards that are essential to the educational purpose or objective of a program or class.

STUDENT SIGNATURE: X ______________________ **DATE:** ______________

Student Name:______________________________

PART III: To Be Completed by Physician

Weight	Height w/o shoes	Temp	Pulse	Resp	BP

Vision Left:______ Right:______ Both:______	❑ Not Corrected ❑ Corrected:______

Describe every abnormality in detail in Part V of form.

Check each item in appropriate column--enter NE if not examined	Normal Findings	Abnormal Findings	Deferred Findings	Comments
Skin				
Eyes				
Ears				
Nose				
Mouth/Teeth/Throat				
Neck				
Breast Examination				
Lungs and Thorax				
Heart				
Abdomen				
Back				
Extremities				
Genitalia				
Neurological				

Depression Screening

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

NOTE: If the patient has a positive response to either question, consider administering the Patient Health Quesitonaire-9 or asking the patient more questions about possible depression. PHQ-2 score ≥ 3 is suggestive of elevated symptoms of depression warranting additional screening or follow-up. Adapted from patient health questionnaire (PHQ) screeners. http://www.phqscreeners.com. Accessed August 2019.

Student must be free of contagion or of any conditions which may endanger the health and well-being of other students or patients and possess sufficient physical stamina with or without reasonable accommodations to fulfill the requirements of the program and the customary requirements of the profession.

Are there any abnormal findings on evaluation for concern? ❑ YES** ❑ NO **(If YES, please explain)

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Printed Name of Physician, Nurse Practitioner, or Physician Assistant______________________________

Signature of Physician, Nurse Practitioner, or Physician Assistant______________________________ **Date** __________

Address______________________________

City/State/Zip ______________________________ **Telephone**______________________________

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Immunization Checklist: *This form cannot be used as documentation!*

Use this checklist to verify completion of immunization requirements. Students must submit provider documentation of all immunizations and titers. Immunization records must include lot#, expiration date, injection site and provider and student information. Lab reports required on all titers. If titer is equivocal or negative, it is mandatory to repeat the series.

Name: ______________________________ DOB: ____________________

PROOF OF THE FOLLOWING IMMUNIZATIONS IS REQUIRED PRIOR TO CLINICALS

COMPLETED	REQUIRED ITEMS	GENERAL NOTES	APPOINTMENT (IF APPLICABLE)
	PHYSICAL EXAMINATION:		
❑ ❑	Primary Care Physician **OR** Nurse Managed Wellness Clinic	Download Physical Form NMWC FORMS & FEES www.allegany.edu/nmwc	
	TUBERCULOSIS SCREENING:		
❑ ❑	2-Step Tuberculin Skin Test (TST) **OR** Blood Test (QuantiFERON or T-Spot)	TB documentation must include lot #, expiration date, injection site and actual MM of induration (range not accepted) Positive, indeterminate & borderline test results require submission of a Chest X-ray report.	Within Past 12 months
	IMMUNIZATION DOCUMENTATION:		
❑	Tdap (Tetanus, diptheria and pertusis)	Within 10 years	
❑	MMR	(Documentation of 2 vaccinations)	
	OR Blood titer for immunity status		
❑	Varicella	(Documentation of 2 vaccinations)	
	OR Blood titer for immunity status		
❑	Heptatitis B	(Documentation of 3 vaccination series)	
	AND / OR Blood titer		
❑	Seasonal Flu Vaccination	Sept. – Mar. yearly	
❑	Nine Panel Drug Screen **Required for Respiratory Therapy Students Only**		
	ALLIED HEALTH REQUIREMENT:		
❑	Allied Health Review Appointment ***Please bring your immunization records to your scheduled appointment with our Nurse Managed Wellness Clinic Nurse Practitioner.***	All student health records will be electronically stored in the NMWC to meet compliance requirements for health career programs.	Call Anna Kephart at x5670 to schedule your appointment
	MEDICAL INSURANCE:		
❑	All students participating in a clinical setting must provide proof of medical insurance.	If you do not have insurance, you will be required to purchase health insurance.	Please provide your health insurance card for documentation.
	CPR CERTIFICATION:		
❑	All students participating in a clinical setting must provide proof of current certification.	AHA Basic Life Support (BLS) for Health Care Providers certification.	

Check the website for specific information regarding immunizations and testing
www.allegany.edu/nmwc

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ALLIED HEALTH PROGRAM ESSENTIAL FUNCTIONS
PROFESSIONAL TECHNICAL STANDARDS

TECHNICAL STANDARDS ACKNOWLEDGEMENT:

I have received a copy of the *Allied Health Program Essential Functions /Professional Technical Standards* as established by the health professions program. I have read these Essential Functions and understand them. I believe I am capable of meeting the Essential Functions of the Allegany College of Maryland health program to which I am applying.

The Health Program is committed to providing educational opportunities to otherwise qualified applicants and students who can perform the functions required of a health professional and to preserving the wellbeing of patients and fellow students; the Program works closely with the Office of Academic Access and Disability Resources if a student has a documented disability for which reasonable accommodations are needed. Applicants are required to provide documentation of a physical examination and submit to the Nurse Managed Wellness Clinic.

Initial ____

POTENTIAL DENIAL OF LICENSURE/CERTIFICATION ACKNOWLEDGEMENT

Please Be Advised: The licensing or certification board may deny a license or certification to any applicant who has been convicted of or pleads guilty or nolo contendere to a felony or to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

Initial ____

ACKNOWLEDGEMENT OF SHARED INFORMATION WITH PROGRAM:

I hereby grant the Nurse Management Wellness Clinic permission to share medical healthcare records with the health profession programs and clinical agencies as required by the program of study.

Initial ____

PRINT STUDENT NAME: ______________________________ **DOB:** ____________

STUDENT SIGNATURE: ______________________________ **DATE:** ____________

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ALLIED HEALTH PROGRAM ESSENTIAL FUNCTIONS
Professional Technical Standards

The role of the student demands intelligence, sound judgment, intellectual honesty, the ability to relate with people and the capacity to react to emergencies in a calm and reasoned manner. An attitude of respect for self and others, adherence to the concepts of privilege and confidentiality in communicating with patients, and commitment to the patient's welfare are essential attributes.

Students participating in the health program must:

- Have the academic ability to learn a large volume of technically detailed Information and be able to synthesize and use this data to solve complex clinical problems. This information must be acquired in a short and intense period of study which requires well developed study skills, a high level of motivation and may require considerable personal and financial sacrifice
- Have the mental, emotional, physical ability, and stamina to complete the program in the required sequence
- Possess the emotional maturity and stability to approach highly stressful human situations in a calm, safe, and rational manner
- Have well developed oral and written English language communication skills
- Be physically and academically prepared to participate in clinical assignments which occur at different times in a variety of geographic locations
- Display strong ethical integrity consistent with working as a health care professional
- Be free of contagion and possess sufficient physical stamina with or without reasonable accommodations and possess mental stability to fulfill the requirements of the program and the customary requirements of the profession to competently perform the technical activities that are a critical part of the program curriculum and profession, including:
    a. work for 10 – 12 hours performing physical tasks requiring physical energy without jeopardy to patient and student safety as, for example, bending, lifting, turning and ambulating adult patients.
    b. perform fine movements and be able to manipulate instruments and equipment.
    c. establish and work toward goals in a consistently responsible, realistic manner.
    d. has auditory ability sufficient to monitor and assess health needs.
    d. has visual ability sufficient for observation and assessment necessary for patient care.

- **Insurance**—students are required to have medical insurance before practicing in the clinical setting; this is NOT provided by the College. Students are responsible for their own health insurance. Personal health insurance information is available through the local health department and at the ACM Business Office located in Room 162 of the College Center building.

- **American Heart Association Health Care Provider CPR certification** is required all programs except Human Services.