MercyCollege of Ohio

Health Screening

To be completed by STUDENT prior to visit with Health Care Provider. *Health Screening, Physical Exam, and Clinical Requirements* documents to be given to Provider for review prior to completion of physical exam.

Student Name (printed) _____ Date of Birth (MM/DD/YYYY) _____ Age _____ Sex Assigned at Birth _____

Address _____ ❒ Home Phone OR ❒ Cell Phone _____

Select your program:

Non-Credit or Certificate	☐ Community Healthcare Worker ☐ EMT/Paramedic ☐ Ophthalmic Assistant ☐ Phlebotomy ☐ Polysomnographic Technology	*Proof of vaccinations are initially accepted (titers may later be required by clinical site)*
Undergraduate Program	☐ AAS Nursing ☐ BSN/ABSN Nursing ☐ Health Information Technology ☐ Healthcare Administration ☐ Medical Imaging ☐ Radiologic Technology	*Proof of positive titers are required; if titers do not show immunity, vaccination series must be repeated (subsequent titer is required for Hepatitis B)*
Graduate Program	☐ Master of Health Administration ☐ Master of Physician Assistant Studies ☐ Master of Science in Nursing	

Medical History

Have you ever been diagnosed with any of the following conditions or illnesses?

Asthma or COPD	Yes ☐ No ☐	Cancer	Yes ☐ No ☐
Diabetes Mellitus	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐
Hepatitis	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
Seizures	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐

Other serious illness or medical condition Yes ☐ No ☐

If the answer is "yes" to any of the above, please explain: _____

_____

Surgeries

Allergies

Current Medications

Office: Academic Affairs
Date: 6/15/21
Health Screening for Student/Provider Use Only (Do NOT Upload to CastleBranch)

Physical Exam

To be completed by PROVIDER

Student Name (printed) _____ Date of Birth (MM/DD/YYYY) _____

Vital Signs:

Height_____(in.) Weight_____(lbs.) BP_____/_____ Heart Rate _____

	Normal	Abnormal	Deferred	Comments
General				
HEENT				
Pulmonary				
Breast, if indicated				
Cardiovascular				
Abdomen				
Back				
Extremities				
Neurologic				
Psychiatric				
Pelvic (if indicated)				
Rectal (if indicated)				

Are there any conditions which may inhibit functioning as a student in a health professional field?

Yes ☐ No ☐

If yes, please explain: _____

_____

Provider's Name (printed) _____ Provider's Title/Credentials _____

Provider's Signature _____ Date _____

Office: Academic Affairs
Date: 6/15/21
Physical Exam for Student/Provider Use Only (Do NOT Upload to CastleBranch)

Clinical Requirements

To be completed by PROVIDER

Student Name (printed) _____ Date of Birth (MM/DD/YYYY) _____

See 530-G *Health Screening* (page 1) for student's program. Student is enrolled in:

☐ Non-Credit or Certificate ☐Undergraduate program ☐ Graduate program

Titers are required for students in undergraduate or graduate programs. Proof of immunization is accepted initially only for students in non-credit or certificate programs.

Required Screenings and Immunizations (lab reports/screening and immunization documentation must be provided to student)

	Date(s) Given	Results	Recorder's Name
Hepatitis B Titer*			
Measles (Rubeola) Titer*			
Mumps Titer*			
Rubella (German Measles) Titer*			
Varicella Titer*			
Tetanus/Diphtheria/Pertussis			
Influenza (see below)			
TB (Tuberculosis) Screen			

***If titers are negative**:

- **Hepatitis B**: 3 doses of Hepatitis B (3-dose series: 0, 1 and 6 months) **OR** (2 dose series: 0 and 2 months). Anti-HBs serologic retest 6-8 weeks after final dose.
- **Measles/Mumps/Rubella** (any negative): 2 doses (0 and at least 28 days later). No serologic retest necessary.
- **Varicella**: 2 doses (0 and at least 28 days later). No serologic retest necessary.

Required Immunizations:

- **Tetanus/Diphtheria/Pertussis**: Include documentation of Tdap during lifetime **AND** proof of adult Td booster or Tdap within past ten years.
- **Annual influenza vaccine for current flu season.** (Influenza vaccines are generally available free of charge to Mercy College students at flu vaccine clinics offered on campus or through Mercy Health).

Required Screening:

- **TB (Tuberculosis)**
  2-step Mantoux PPD; **OR** previous 2-step Mantoux PPD with subsequent annual 1-step PPD screenings; **OR** Serum T-Spot or QuantiFERON test; **OR** if student has had the BCG vaccination, serum T-Spot or QuantiFERON test
  a) If TB screen is *positive*, negative chest X-ray radiology report within past 5 years with negative TB Symptoms Review
  b) If chest X-ray is *not* negative, one of the following is required:
     i) Confirmation of appropriately collected negative sputum results; **OR**
     ii) proof of adequate treatment and medical clearance (free from communicable diseases) with appropriate follow-up as indicated by Provider.

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Date: 6/15/21
Clinical Requirements for Student/Provider Use Only (Do NOT Upload to CastleBranch)

Confirmation of Physical Exam and Clinical Requirements Clearance

To be completed by PROVIDER

_____ _____
Student Name (printed) Date of Birth (MM/DD/YYYY)

Are required screenings and immunizations appropriately up to date? **Students are allowed to be in-process, as long as they remain current with screening/immunization schedules**.

Yes ❑ No ❑

If no, please explain: _____

_____

_____

I medically clear this student for entry into a health program at Mercy College of Ohio.

Yes ❑ No ❑

If no, please explain: _____

_____

Lab reports/screening and immunization documentation must be provided to student.

_____
Practice Name

_____
Practice Address (include City, State, Zip)

_____
Practice Phone Number

_____ _____
Provider's Name (printed) Provider's Title/Credentials

_____ _____
Provider's Signature Date

Office: Academic Affairs
Date: 6/15/21
Student: Upload 530-H to Physical Exam Confirmation Requirement in CastleBranch