COLUMBUS STATE COMMUNITY COLLEGE

EKG

HEALTH HISTORY
To be completed by the student:

PLEASE PRINT ALL INFORMATION   **COUGAR I.D.**_____

Name:_____
             Last   First   Middle

Address: _____
          Street   City   State   Zip

Date of Birth:_____   Phone: _____
           Month/Day/Year   Home   Other

Program of Study: _____

Semester to Begin Program:_____   E-mail:_____

Answer all questions. If the answer is "no, none, not applicable", write that as your answer. Make certain you have entered your program of study above so we will know which requirements apply to you.

List all allergies and sensitivities you have including medications, food, & environmental:

_____
_____
_____

List all surgical operations you have had with the date:

_____
_____
_____

List all current health conditions you have:

_____
_____
_____

List any previous significant health problems you have had:

_____
_____
_____

_____
      Student Signature   Date

Covid Card verifying complete series or exemption request must be uploaded in Immuware

Cougar ID_____

COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORD

Physical Examination: Must be performed by Physician, Nurse Practitioner or Physician's Assistant

Name:_____ D.O.B._____
           Last   First   Middle

Allergies: _____

Medications: _____

Height: _____   Weight: _____   Pulse: _____   B/P:_____

EXAMINER: Indicate your findings after examination of each system

        EENT: _____

        NEURO: _____

        CV: _____

        RESP: _____

        ENDOCRINE: _____

        MUSC/SKEL: _____

☐   If this student has any reaction to latex, please complete the Examiner's portion of the "Latex Reactions Form" that the student will supply to you. **http://cscc.edu/Students/FormsPDF/health/LatexReactionForm.pdf**

☐   If this student is subject to any health emergency, please provide special emergency instructions below.

☐   If there is additional significant information about this student which would relate to his or her safety for patients or for self in a clinical or laboratory situation, please provide information below.

Does student have any functional limitations or restrictions that would prevent him/her from working in a patient care area?	Yes	No
Vision, such as reading gauges or thermometers?		
Hearing, such as in a classroom or when using a stethoscope?		
Speech, such as in a classroom?		
Lifting up to 50 pounds?		
Ambulation/Standing for several hours?		
Ability to handle stress?		
Sensorimotor (fine and gross)?		

Does the student have any limitations or restrictions? If no, please document below "No restrictions/No limitations". If **yes**, please

provide specific facts regarding student's requirements. _____

_____

        Examiner's Signature: _____

        Print Examiner's Name: _____

        Address: _____

        Phone:_____   Date: _____

COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORD

Tuberculosis Testing

Name: _____

Tuberculosis Testing

Two-Step Mantoux (intradermal) is required. This involves two Tb Mantoux tests at least 7 days apart and within the last year. Two or three days after each Tb test is given it must be read by the physician, nurse, or physician's assistant. Tb tine tests are not acceptable per state regulations. Two Mantoux tests within the past year can be substituted per state regulations. <u>If the student recently received an MMR or varicella vaccine, the tuberculosis test must be postponed until at least four to six weeks after the MMR.</u>

Tb#1   **Tb#2** At <u>**least 7 days after the first Tb test**</u>:
Date given:_____   Date given:_____
Date read:_____   Date read: _____
Result:_____mm   Result:_____mm

Read by:_____   Read by: _____

If this test or a previous test is positive: Submit documentation of positive PPD and a negative chest x-ray report from within the past five years. If your previous chest x-ray or positive PPD has been more than a year ago, please complete an Annual Health Evaluation form found at https://www.cscc.edu/services/hr_pdf/Annual.pdf

==**Please note: QFT Gold or T Spot are acceptable in place of a one or two step Tuberculosis skin test and must be current.**==

Facility Name: _____

Address: _____

Phone:_____   Date: _____

COLUMBUS STATE COMMUNITY COLLEGE
SUPPLEMENTARY IMMUNIZATION RECORD

NAME_____   D.O.B. _____

PROGRAM_____   COUGAR ID#_____

TO BE COMPLETED BY THE PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT

THE FOLLOWING IMMUNIZATIONS ARE *REQUIRED*:

1. **Hepatitis B**: Dates of Hepatitis B immunization: #1_____, #2_____,
    #3_____(Must have immunizations #1 and # 2 completed before submitting health record
    and final immunization completed on schedule.)
    OR
    *Date and results of hepatitis B **surface antibody** _____
    NOTE: If the surface antibody is negative, the student must receive the immunization series.

2. **MMR:** Date of first immunization_____Date of second_____
    OR
    *Date and results of Rubeola IGG titer_____, *Mumps IGG titer_____,

    *Date and results of Rubella IGG titer_____.
    NOTE: If titer is negative, the student must receive the immunization series.

    **DO NOT RECEIVE MMR IMMUNIZATION WHILE YOU ARE COMPLETING THE
    TWO-STEP TUBERCULOSIS TEST.** The measles component invalidates the tuberculosis test,
    so you would have to repeat the tuberculosis testing which may delay your ability to register into
    your program.

3. **Chickenpox/Varicella**: Date of first immunization_____Date of second _____
    Both immunizations required before submitting health record.
    OR
    *Date and results of varicella **IGG** titer _____
    NOTE: If titer is negative, the student must receive the immunization series.
    HISTORY OF DISEASE/ILLNESS IS NOT ACCEPTABLE DOCUMENTATION!

    **DO NOT RECEIVE THE VARICELLA IMMUNIZATIONS WHILE YOU ARE COMPLETING THE
    TWO-STEP TUBERCULOSIS SKIN TEST.**

4. **Tdap/Td:** (Tetanus/Diphtheria/Pertussis) per CDC guidelines _____

5. **Flu Vaccine:** _____ **(CURRENT SEASONAL FLU REQUIRED)**
    Must provide current lab work for series 20 years or older

Signature: _____

Printed Name and Title: _____

Organization: _____

Phone: _____   Date: _____

<u>INSTRUCTIONS FOR COMPLETION OF HEALTH RECORD and Acknowledgment form</u>
<u>(Digital in Immuware)</u>

1. Please read and follow all instructions so we can process your records as quickly and accurately as possible. If you do not follow instructions or do not submit **complete information**, processing of your health record might be delayed, which might delay your ability to register into your courses. ***All information must be <u>complete</u> before uploading and before you will be eligible to register.***

2. If you are providing photos, please ensure the photos are light and clear; no other objects are to be present in your photo other than your documents.

3. The health history and physical must be on CSCC forms. If you have had a physical examination within the past year, it must be transcribed on CSCC Physical form by the physician, physician assistant, or nurse practitioner.

4. It is **<u>your responsibility</u>**, not your physician's, to make certain that all health requirements have been completed and documentation of all items is submitted to the college. Please verify that you have the appropriate documents prior to submitting them to the college.

5. Records will not be reviewed until all health requirements for your program have been uploaded. Records are processed in the order they are received. Completed health records received by the deadline are processed within 1-5 business days. Completed health records received after the deadline are processed within 5-10 business days from the date of submission

6. **Please ensure you have uploaded all required documentation to Immuware before calling health records to inquire about your submission.**

QUESTIONS?? Call 614-287-2450

The information you are reporting to Columbus State Community College, Office of Student Health Records is used to meet the health requirements determined by the college's clinical affiliates, and to verify your ability to perform essential functions of the clinical tasks safely.

It is the policy of Columbus State Community College not to discriminate against any individual. This assurance of non-discrimination includes applicants for academic admission, and shall be applied regardless of sex, race, color, religion, national origin, ancestry, age, disability, genetic information (GINA), military status, sexual orientation, and gender identity and expression.

I certify that the health information I have given is accurate and complete. I understand that providing false information on this document is a serious offense which will result in disciplinary action. I understand that if my health, physical condition, or physical abilities change during my enrollment in a health-related program at Columbus State Community College I must report these changes to my program coordinator and to the Student Health Records Office. I understand that physical exam and tuberculin testing results may be released to clinical sites prior to my clinical/practicum experiences. I understand that conditions which may affect my ability to perform essential functions of the clinical tasks, or which may affect my ability to function with safety for myself and/or others might be discussed with my department chair or program coordinator.

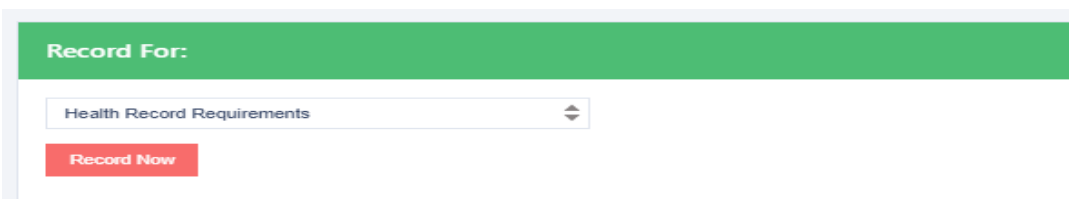# INSTRUCTIONS FOR SUBMITTING YOUR HEALTH RECORD IN IMMUWARE

1. Request access to Immuware by scanning the QR code below or use the following link
   https://web.cscc.edu/forms/immuware.php

2. A confirmation email regarding your request will be sent to your CSCC student email account

3. You will receive a **Welcome Email** from Immuware when your access to Immuware is ready. Please allow up to 24 hours to receive this email from the time you submit your request

4. Scan the QR code below or use the following link to login to Immuware: https://cscc.immuware.com
   The link in the Welcome Email will be the same

5. You will use your CSCC login and password to login to Immuware

6. You will see the Health Record Requirements under your name, please click the "Record Now" button, select Status Details, choose Student Requirements then select your program of Study (*)

7. Read through all instructions in Immuware to ensure you are submitting your documents properly

8. Please ensure your documents are fully complete before you upload each page and ensure you enter all dates correctly

* DO NOT SELECT THE RN PROGRAM UNLESS YOU HAVE RECEIVED AN OFFICIAL LETTER OF ACCEPTANCE FROM THE NURSING PROGRAM COORDINATOR. IF YOU SELECT THE RN PROGRAM, PLEASE ALLOW 48 BUSINESS HOURS TO VERIFY YOUR ADMISSIONS INTO THE RN PROGRAM.