

COLUMBUS STATE COMMUNITY COLLEGE

Veterinary Technology

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

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://csc.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
Veterinary Technology Program
Health, Physical Capability, and Risk Assessment (HPCR)**

Applicant's Name: _____

Date of birth & Age: _____ **Year:** _____

To be completed by a Physician, Nurse Practitioner or Physician's Assistant:

Physical capabilities:	Please circle Answer:	
Vision Capabilities		
Applicant has normal or corrected refraction within 20/20.	Yes	No
Applicant is able to distinguish color shade changes.	Yes	No
Auditory Capabilities		
Applicant possesses normal or corrected hearing ability within 0 to 45 decibel range.	Yes	No
Tactile Capabilities		
Applicant can perform fine motor skills.	Yes	No
Applicant possesses in at least both hands the ability to perceive temperature change and pulsations and to differentiate between various textures and structures.	Yes	No
Language Capabilities		
Applicant possesses the ability to verbally communicate in English.	Yes	No
Motor Capabilities		
Applicant has the ability to raise both arms above their head.	Yes	No
Applicant possesses 4 functional limbs (natural or artificial).	Yes	No
Applicant can grasp securely with both hands.	Yes	No
Applicant can stand for long periods of time.	Yes	No
Applicant can walk unassisted.	Yes	No
Applicant can lift up to 60 pounds.	Yes	No

Statement of Licensed Medical Practitioner

I hereby certify that the above-named applicant has been examined by me on this date and meets or exceeds the physical capability requirements stated above. I have also reviewed the VT occupational hazards with them and feel that they understand the associated risks.

Examiner's Signature: _____

Print Examiner's Name: _____

Address: _____

Phone: _____ Date: _____

Statement of Applicant

I have reviewed the VT occupational hazards with my medical practitioner and understand the associated risks. If I become aware that I have an increased risk of injury from an occupational hazard, I will seek the advice of my medical practitioner immediately and institute appropriate precautionary measures under their guidance.

Student Signature: _____

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. 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.

Tb#1

Date given: _____

Date read: _____

Result: _____ mm

Read by: _____

Tb#2 At least 7 days after the first Tb test:

Date given: _____

Date read: _____

Result: _____ mm

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.csc.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. **Rabies:** *Date of first immunization _____ *Date of second _____

OR

*Date and results of Rabies antibody titer _____

OR

*Date of signed rabies waiver form (also attached) _____

****Rabies series, titer, religious/medical exemption, or declined rabies vaccine documents must be signed or placed within the past 2 years****

2. **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.

****Must provide current lab work, for varicella series that are 20 years or older****

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

Signature: _____

Printed Name and Title: _____

Organization: _____

Phone: _____ Date: _____

Acknowledgement and Assumption of Risk Declined Rabies Vaccination

This form must be signed by any student who requests a medical or religious exemption to Columbus State Community College Veterinary Technology rabies immunization requirement:

I have chosen to participate in Columbus State Community College Veterinary Technology Program (CSCC VTP). Participation in Columbus State's VTP will involve contact with animals and may give rise to a risk of physical injury or infection.

I understand that:

1. Animals have a tendency to behave in ways that may result in injury to me or other persons in the immediate vicinity.
2. Animals may react in an unpredictable way to unfamiliar environments, sounds, odors, sudden movements, unfamiliar objects, persons, or other animals.
3. I must listen to on-site professional staff when working with animals and when I am around other students, faculty, visitors, or staff.
4. Animals may become aggressive toward people during treatment.
5. Animals may carry diseases that may not be apparent, and these diseases may be infectious to humans.
6. I must comply with all the CSCC Veterinary Technology Program policies, regulations and rules, and all federal, state, county, city, and/or local laws, regulations, and ordinances regarding the care and treatment of animals at CSCC.

Further, I acknowledge and understand that participation in the CSCC-VTP increases my risk of being exposed to infections and diseases, including rabies. Rabies is a lethal viral infection that is typically spread to susceptible animals and humans by bites from infected animals or by close contact with infected tissues. The disease has a low prevalence in Central Ohio but has been identified in dogs, cats, horses and wildlife throughout state. CSCC VTP requires that veterinary technology students and employees obtain vaccination against the disease and verify titers are in compliance with CDC recommendations:

https://www.cdc.gov/rabies/specific_groups/veterinarians/staff.html

By signing below, I acknowledge that I have not received immunization with the human rabies vaccination within the last two years and have not had a titer drawn in the last two years. By declining or failing to maintain compliance with this immunization, I understand and accept that I am increasing my risk of contracting the lethal infection.

I hereby attest and verify that I have been advised of the potential risks, have sought clarification if I have not understood, that I have full knowledge of the risks involved in these activities, and that I assume any expense that may be incurred in the event of an accident, injury, other incapacity, or infection.

I understand that this is a legal document which is binding on me, my heirs and assigns, and on those who may claim by or through me. I verify that I am eighteen years of age or older and have full capacity to enter into this agreement and do so knowingly and voluntarily.

I declined immunization against rabies, have not received immunization with the human rabies vaccination within the last two years, and have not had a titer drawn in the last two years and understand that by doing so, I increase my risk of contracting rabies and, if contracted, the disease is fatal.

Signature: _____

Date: _____

Printed name: _____

Student ID: _____

INSTRUCTIONS FOR COMPLETION OF HEALTH RECORD and Acknowledgment form
(Digital in Immuware)

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 **complete** 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 **your responsibility**, 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.

Student Signature

Date

INSTRUCTIONS FOR SUBMITTING YOUR HEALTH RECORD IN IMMUWARE

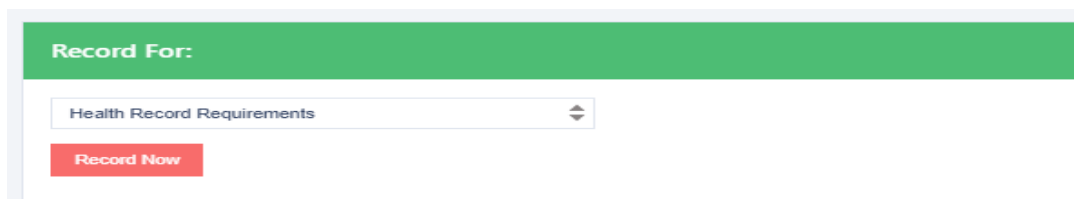
1. Request access to Immuware by scanning the QR code below or use the following link
<https://web.cscs.edu/forms/immuware.php>



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://cscs.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 (*)



The screenshot shows a web interface with a green header bar containing the text "Record For:". Below this is a dropdown menu with "Health Record Requirements" selected. A red button labeled "Record Now" is positioned below the dropdown.

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.**