# Los Angeles Mission College –Health Record Form

Take these documents to your physical exam appointment.

(This section is to be filled out by the student.)

Name (last, first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LACCD email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­**Area(s) of study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Training Program**

Circle any disease(s) below that you may have had or have:

Anemia Arthritis Asthma Allergies Chicken Pox Long Covid-19

Diabetes Heart Problems Epilepsy Cancer Kidney problem Measles

Mumps Pneumonia Polio Smallpox Thyroid Disorders Tonsillitis

Have you had any operations in the past? Please list them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? If yes, please explain! \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history (circle and note relative):

Tuberculosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Exam (This section is to be filled out by the healthcare professional.)**

|  |  |
| --- | --- |
| GENERAL APPEARANCE: | DENTAL HYGIENE: |
| HEIGHT: | THROAT: |
| WEIGHT: | ABDOMEN: |
| POSTURE: | GLANDS: |
| SKIN: | THYROID: |
| BACK: | LUNGS: |
| EYES / RETINA / PERRLA: | HEART: |
| EARS / HEARING | PULSE: |
| NOSE: | ENDOCRINE SYSTEM Disorders: |
| BLOOD PRESSURE: | NERVOUS SYSTEM Disorders: |

**IMMUNIZATION/TITER TEST + DRUG TEST**

| **Specific Test/Vaccine** | **Date(s)** | **Results** | **Examiner’s Initials** |
| --- | --- | --- | --- |
| Tuberculin Skin Test  OR QuantiFERON Gold TB Test OR Chest X-ray  (Note: It is recommended to do the QuantiFERON Test to avoid double testing) |  |  |  |
| Hepatitis B (Titer/Vaccine) |  |  |  |
| Measles (Titer/Vaccine) |  |  |  |
| Mumps (Titer/Vaccine) |  |  |  |
| Rubella (Titer/Vaccine) |  |  |  |
| Polio (Titer/Vaccine)  If not applicable, please write not applicable (N/A) with explanation for clearance |  |  |  |
| Varicella (Chicken Pox) (Titer/Vaccine) |  |  |  |
| Diphtheria/Tetanus  (If you had the series as a child, then all you need is the booster within the last ten years). |  |  |  |
| COVID-19  (Vaccinations and boosters are required by healthcare facilities where clinical training takes place. Include record.) |  |  |  |
| Flu Vaccine (when applicable) Highly recommended (some facilities require the vaccine) |  |  |  |
| Drug Screen  (8-panel minimum – if not available, please provide an order)  Must provide the list of drugs tested with results. |  |  |  |

If the titer is negative or does not show immunity, submit a record of receiving the vaccinations. Then, a repeat titer as designated per medical protocol. Copies of all laboratory reports are required (i.e., drug test and/or titers).

The applicant is free of conditions that will prevent participation in the clinical practice of the Training Program Y\_\_ N\_\_

Recommendations/notes by the healthcare practitioner:

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Examined by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare practitioner’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_