

**KINGSBOROUGH COMMUNITY COLLEGE**  
**2001 ORIENTAL BOULEVARD**  
**BROOKLYN, NEW YORK 11235**

**Health Center**

***HEALTH REQUIREMENT FOR SURGICAL TECH / EMS / PSG***

**PLEASE MAKE (3) COPIES OF ALL MATERIALS**

Faculty in the clinical phase of the Surgical Tech, EMS, and Paramedic programs must complete ALL of the following requirements as indicated and bring them to the Health Center, Room A108.

**DEADLINE DATE:** \_\_\_\_\_

Student's Name: \_\_\_\_\_ S.S. #: \_\_\_\_\_

- \_\_\_\_\_ 1. Complete physical done by a private physician
- \_\_\_\_\_ 2. Urinalysis and drug screen 10 panel with lab results
- \_\_\_\_\_ 3. 2 step PPD/Quantiferon Blood Test
- \_\_\_\_\_ 4. TDAP                      Date: \_\_\_\_\_
- \_\_\_\_\_ 5. Hepatitis B Immunization  
    1<sup>st</sup> Date: \_\_\_\_\_ 2<sup>nd</sup> Date: \_\_\_\_\_ 3<sup>rd</sup> Date: \_\_\_\_\_  
    or Declination if the series is incomplete
- \_\_\_\_\_ 5a Hepatitis HbsAB Titer – lab report required  
    Hepatitis HbsAG Titer – lab report required
- \_\_\_\_\_ 6. Hepatitis C antibody
- \_\_\_\_\_ 7. Serology (VDRL) lab report required
- \_\_\_\_\_ 8. Complete blood count (CBC)
- \_\_\_\_\_ 9. Varicella titer - lab report required
- \_\_\_\_\_ 10. Rubeola (measles) titer - lab report required
- \_\_\_\_\_ 11. Rubella (German measles) titer - lab report required
- \_\_\_\_\_ 12. Mumps titer - lab report required
- \_\_\_\_\_ 13. Flu vaccination

Physician's Stamp: \_\_\_\_\_ Date: \_\_\_\_\_

**NEW CLINICAL SURGICAL TECH / EMS / PARAMEDIC / PSG**

<b>PPD Placed</b> _____	<b>Site:</b> _____	<b>Lot #:</b> _____	<b>Brand:</b> _____	<b>By:</b> _____
(date)				(signature)
<b>Results:</b> _____ mm induration <b>Date:</b> _____ <b>Signature:</b> _____				
<b>License #</b> _____				
<b>PPD Booster: Placed:</b> _____	<b>Site:</b> _____	<b>Lot #:</b> _____	<b>Brand:</b> _____	<b>By:</b> _____
(date)				(signature)
<b>Results:</b> _____ mm induration <b>Date:</b> _____ <b>Signature:</b> _____				
<b>License #</b> _____				
<b>Booster must be placed between 1 and 3 weeks</b>				
<b>CHEST X-RAY:</b>	<b>DATE:</b> _____	<b>RESULTS:</b>	_____	

**Quantiferon Blood Test Acceptable in place of 2 Step PPD.**



## HEALTH CENTER MEDICAL RECORD

Medical records are confidential and are kept under secure conditions. They are used only by authorized personnel for the purpose of furnishing counseling service and assistance.

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Last First Middle Former

\_\_\_\_\_ No. Street City State Zip Code

HOME TELEPHONE NO: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_ PHONE: \_\_\_\_\_

### PERSONAL HISTORY

CHECK AND DESCRIBE BELOW:

CONDITION	YES	NO	CONDITION	YES	NO
ALLERGIES			HEART		
ASTHMA			INJURIES		
CANCER, CYSTS, TUMOR, ETC.			KIDNEY		
CONVULSIONS OR EPILEPSY			MUSCULO-SKELETAL		
DIABETES			NERVOUS		
DRUG HABIT			RHEUMATIC FEVER		
EARS			THYROID		
EYES			TUBERCULOSIS		
FAINTING			VENEREAL DISEASE		
GASTRO-INTESTINAL					

1. DESCRIBE ANY ITEM CHECKED YES: \_\_\_\_\_

2. LIST ANY PREVIOUS SERIOUS ILLNESSES AND OPERATIONS: \_\_\_\_\_  
/DATE \_\_\_\_\_

CHECK BOX IF ANY PHYSICAL HANDICAPS:

- A. ☐ WHEELCHAIR BOUND  
B. ☐ BLIND OR PARTIALLY SIGHTED  
C. ☐ USE BRACES AND CRUTCHES  
E. ☐ NEUROLOGICAL IMPAIRMENTS (POLIO, CEREBRAL PALSY, ETC.)  
F. ☐ SPEECH IMPEDIMENTS  
G. ☐ OTHERS – DESCRIBE: \_\_\_\_\_

DESCRIBE DISABILITY BRIEFLY: \_\_\_\_\_

# **PHYSICAL EXAMINATION**

(TO BE COMPLETED BY A LICENSED PHYSICIAN)

TUBERCULIN PPD  
HEIGHT \_\_\_\_\_ IN. WEIGHT \_\_\_\_\_ LBS. VISION O.D. \_\_\_\_\_ CORR. \_\_\_\_\_ (MANTOUX TEST). DATE \_\_\_\_\_ RESULT \_\_\_\_\_

O.S. \_\_\_\_\_ CORR. \_\_\_\_\_ CHEST XRAY: DATE: \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ RESULT \_\_\_\_\_

B.P. \_\_\_\_\_ / \_\_\_\_\_ mmHg. PULSE \_\_\_\_\_ /min.

Hgb. \_\_\_\_\_ Gm. %

NORMAL	ABNORMAL		REMARKS – DESCRIBE ABNORMALITIES ONLY
		HEAD & NECK	
		NOSE AND SINUESE	
		MOUTH AND THROAT	
		GUMS AND TEETH	
		EYES	
		EARS, HEARNG	
		CHEST, BREASTS, LUNGS	
		HEART	
		VASCULAR SYSTEM	
		ABDOMEN AND VISCERA	
		HERNIA	
		ANUS AND RECTUM	
		SPINE AND MUSCULOSKELETAL	
		GENITO-URNARY SYSTEM	
		SPINE AND MUSCULOSKELETAL	
		SKIN-IDENTIFYING MARKS, SCARS, TATTOOS	
		NEUROLOGIC	
		PSYCHIATRIC	

IS THERE ANY EMOTIONAL, MENTAL OR PHYSICAL CONDITION FOR WHICH THIS STUDENT IS UNDER MEDICAL OBSERVATION AND/OR TAKING MEDICATION: ☐ YES ☐ NO  
SPECIFY: \_\_\_\_\_

PHYSICIAN'S NAME (PRINT) \_\_\_\_\_

SIGNATURE \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE OF EXAMINATION: \_\_\_\_\_

**ATTENTION:** NURSING, SURGICAL TECH, EMS, PARAMEDIC, PSG FACULTY

Pursuant to section 405.3 (b) of the New York State Hospital Codes, the following Statements of Physical Examination is required:

I have examined \_\_\_\_\_ on \_\_\_\_\_

Based on my physical examination and the patient's medical history, I believe that the above-referenced is free from a health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

Physician's signature \_\_\_\_\_

License number \_\_\_\_\_

(PHYSICIAN'S STAMP)