CALHOUN COMMUNITY COLLEGE
HEALTH SCIENCES DIVISION
PHYSICAL EXAM

To the Student:  Complete Part I on the Physical Exam Only.

I. Name: ___________________________________ Calhoun ID:___________________
   Program of Study:  CLT  DAT  EMS  NUR  PTA  SUR
   Date of Birth: ____________ Age: ___________ Gender: ____________
   Allergies (Describe agent and reaction): ____________________________________________
   Currently Pregnant:  ___ Yes  ___ No
   Emergency Contact: Name: _______________________________ Phone: _______________

To the Physician: Please complete the following form based on clinical findings and knowledge of the
student’s past medical history.

II. Height: ___________ Weight: ___________
   Vision: 20/____ OS  20/____ OD  Corrected by: ___ Glasses ___ Contact lens
   Temp: ___________ Pulse: ___________ Resp: _______ BP: _____/_______
   Physical Examination (Notes):
   HEENT: ________________________________________________________________
   CVR: _________________________________________________________________
   ABD: _________________________________________________________________
   GU: _________________________________________________________________

Please state any significant medical history or limitations for this student:
________________________________________________________________________
________________________________________________________________________

NOTICE: The Alabama Infected Health Care Worker Management Act mandates that any health care worker who performs
invasive procedures and who is infected with human immunodeficiency virus (HIV) or hepatitis B virus shall notify the State Health
Officer or his designee of the infection.

To The Physician: Please record the answers to the questions below. Some questions require input
from the student. Others will be obtained from the examination.

YES  NO
Does the student have, at a minimum, vision in one eye corrected to 20/20?
Does the student have visual ability to include color perception?
Does the student have the ability to send and receive verbal messages?
Does the student meet the “Essential Functions” of the program? See Last Page

III. IMMUNIZATIONS AND LABORATORY TESTS
Instructions: Please note that the student has received the following immunizations and/or lab
tests. Immunizations and lab test(s) required are:

Confirmed or administered
1. Tetanus/D within the past ten years
2. Varicella Vaccine – 2 vaccines (Chicken Pox), or Varicella Titer
3. MMR Vaccine prior to 1969, or Rubella Titer of 1:8 or above is sufficient in lieu of MMR
4. Two-step TB Skin Test or Chest X-Ray (if positive)
5. Hepatitis B Vaccination Series – proof of series completion or proof of immunity
   NOTE:  Students with incomplete series or choosing not to be vaccinated must sign the Vaccination Waiver
   printed on page 3.
6. Influenza Vaccination required during influenza season or must sign waiver (Documentation Required)
# To the Physician:

<table>
<thead>
<tr>
<th><strong>Mantoux Two-Step TB Skin Test</strong></th>
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</thead>
<tbody>
<tr>
<td><em>Please initial behind date</em></td>
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<tr>
<td>[See page 4 for details]</td>
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<td></td>
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</tbody>
</table>
| **1st Step** Date Given:_____ by:____
| **1st Step** Date Read:_____ by:____ Results:______ |
| **2nd Step** Date Given:_____ by:____
| **2nd Step** Date Read:_____ by:____ Results:______ |

<table>
<thead>
<tr>
<th><strong>Hepatitis B Vaccination</strong></th>
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<tr>
<td>[See page 4 for details]</td>
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<tr>
<td><strong>1st Date</strong>_______ <strong>2nd Date</strong>_______ <strong>3rd Date</strong>_______</td>
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<tr>
<td>Titer Date: _____________ Immunity: ____ No Immunity: ____</td>
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<table>
<thead>
<tr>
<th><strong>MMR &amp; Tetanus</strong></th>
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<tbody>
<tr>
<td>MMR Vaccine Date: ___________ Tetanus Date: ___________ or</td>
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<tr>
<td>Rubella Titer Date: ___________ Immunity: ____ No Immunity: ____</td>
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<tr>
<th><strong>Varicella Vaccine</strong></th>
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<tr>
<td>4-8 weeks apart</td>
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<tr>
<td>Immunization Dates: ___________ ___________ or</td>
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<td>Titer Date: ___________ Immunity: ____ No Immunity: ____</td>
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<tr>
<th><strong>Influenza Vaccine</strong></th>
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<tr>
<td>Date of Vaccine: ___________</td>
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<tr>
<td>Location Given: ___________ or Sign Waiver</td>
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**To The Physician:**

I certify that of this date, __________, I have examined ____________________________ and found this person to be physically and mentally able to carry out the essential functions as assigned in the clinical setting as listed on the Essential Functions insert in this document, and I have verified the student is free of infectious disease (including tuberculosis) as confirmed by the lab tests and/or any other medical/laboratory test I have deemed necessary.

__________________________________________
Signature of Physician or Nurse Practitioner

__________________________________________
Phone

Please Print Physician or Nurse Practitioner Name

__________________________________________
Address

__________________________________________
City State Zip

__________________________________________
Date of Signature

June, 2014
Hepatitis B Vaccination Waiver
(To be completed only if the Hepatitis B Vaccine is declined or if the series has not been completed)

I have read the Hepatitis B Vaccination information provided by the Calhoun Community College Health Division. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. Understanding the foregoing, I accept responsibility for making the decision to decline the HBV vaccine. **I DO NOT** consent to the administration of the vaccine. I understand the risks involved and I take full responsibility of any actual or potential hazards to my health. I agree to hold Calhoun Community College and all of its agents, officials, or employees harmless if I should contact this disease during or after my attendance at Calhoun Community College.

Student Signature __________________________________________ Date __________

Proof of Health Insurance

I understand that, as a Health Division student at Calhoun Community College, it is strongly recommended that I have health insurance. I understand that if I experience injury or illness as a student fulfilling educational activities at a clinical facility, emergency treatment will be provided by that facility at my expense. I have chosen to provide proof of Health Insurance coverage while enrolled in one of the Health Science programs and have supplied a copy of my insurance card to the Health Division. With that knowledge and understanding, and on behalf of myself, my heirs, and administrators, I hereby release Calhoun Community College, its employees, officials, agents, and representatives from any claim of liability for injury, loss, damage, or death that may result or arise from my experience as a student of the Health Sciences Division.

Student Signature __________________________________________ Date __________

**Please attach a copy of your health insurance card**

Health Insurance Waiver of Liability

I understand that, as a Health Division student at Calhoun Community College, it is strongly recommended that I have health insurance. I understand that if I experience injury or illness as a student fulfilling educational activities at a clinical facility, emergency treatment will be provided by that facility at my expense. I have been informed of the importance of this recommendation and have elected to sign this waiver, verifying that I have chosen not to have health insurance coverage. With that knowledge and understanding, and on behalf of myself, my heirs, and administrators, I hereby release Calhoun Community College, its employees, officials, agents, and representatives from any claim of liability for injury, loss, damage, or death that may result or arise from my experience as a student of Health Sciences Division.

Student Signature __________________________________________ Date __________

Influenza Vaccination Refusal/Declination

I understand that, as a Health Division student at Calhoun Community College, I am required to provide documentation of the influenza vaccination or documentation of declination of the influenza vaccination. I understand this is a requirement of the clinical agency. I **DO NOT** consent to the administration of the influenza vaccine for the reason listed below and agree to attach the required documentation to validate the reasons for my declination: **Required documentation attached.**

Reason: ______________________________________________________________________

Student Signature __________________________________________ Date __________
TUBERCULOSIS SCREENING REQUIREMENT

All students entering a Health Sciences program at Calhoun Community College must submit documented results of a two-step Mantoux PPD skin test for tuberculosis. The test must be done AFTER JANUARY 1 of the current year. The documented test results must be scanned or faxed to Employment Screening Services (ESS).

The Two-Step Mantoux PPD
The Mantoux test uses a syringe. A Tine Test uses a four-pronged puncture device (The Tine Test will not be accepted).

1. Have the first PPD skin test, have the results read and recorded within specified time period.

    AND

2. Have a second PPD skin test the following week and have these results read and recorded within specified time period.

Dates of each PPD and reading must be documented and scanned or faxed to (ESS). Students who have already submitted results of a two-step Mantoux PPD, must, thereafter, submit the results of a yearly Mantoux PPD with the most recent one having been done after January 1 of the current year.

ANYONE HAVING A POSITIVE PPD SKIN TEST FOR TB IN THE PAST SHOULD NOT HAVE THE PPD SKIN TEST REPEATED.

Should the PPD skin test be positive or if you have had a positive PPD skin test at anytime in the past, you must have the results of a chest x-ray done after January 1 of the current year. The results and a form completed by your physician must be scanned or faxed to ESS. (All forms can be obtained in the Health Division Office). To have the form mailed to you, please call (256) 306-2786 or (256) 306-2794. Note: Chest X-Ray results are good for two (2) years. A positive TB skin test questionnaire must be completed each year.

NOTE: Students who have already submitted results of a Two-Step Mantoux PPD, must thereafter submit the results of ONE yearly Mantoux with the most recent one having been completed after January 1 of the current year. Likewise, any student who can present documentation results of three (3) negative Mantoux PPD’s given over the past three years (i.e. 2012, 2013 and the third on or after January 1 of the current year) will not be required to have a two-step Mantoux PPD. The last negative test must be after January 1 of the current year.

The two-step PPD skin test or the yearly PPD skin test can be obtained from your private physician. If you have any questions, please contact the Health Sciences Division at (256) 306-2786 or (256) 306-2794.
HEPATITIS B INFORMATION SHEET

Type B Hepatitis
Type B hepatitis is an infection of the liver caused by the hepatitis B virus (HBV). The hepatitis B virus is transmitted by infective blood or body fluids. Infective blood or body fluids can be introduced by contaminated needles, by unapparent or unnoticed contact with infectious secretions from skin lesions or mucosal surfaces, or through sexual contact.

Hepatitis B is the most commonly reported type of hepatitis in the United States. It is an unpredictable disease with a variety of presentations and outcomes. It is estimated that 60–75% of people who are infected do not become ill. In this circumstance prior infection can only be detected by presence of antibody in the blood. Acute symptomatic hepatitis B infection may result in serious liver injury which may incapacitate a person for weeks to months. Approximately 6–10% of persons with type B hepatitis become carriers of the virus and death occurs in 1–2% of patients either as a result of acute liver failure or complications. Hepatitis B virus also has a role in the development of cirrhosis and liver cancer. There is no effective treatment for hepatitis B infection or disease.

Hepatitis B Vaccine
The Recombinant hepatitis vaccine is a genetically designed vaccine derived from yeast (not plasma). It is indicated for active immunization against infection caused by all known subtypes of hepatitis B virus. It will not prevent hepatitis caused by other agents, such as hepatitis A virus, non-A, non-B hepatitis viruses, or other viruses known to infect the liver. Full immunization requires three (3) intramuscular doses of vaccine given over a six month period. In an adult the vaccine should be administered in the deltoid muscle of the arm. The vaccine has been found to be effective in producing hepatitis B antibodies at protective levels in more than 90% of healthy individuals who received the recommended three doses of the vaccine in the deltoid muscle of the arm. The duration of immunity is unknown at this time. A small percentage of healthy persons do not respond to the vaccine and do not develop immunity to HBV. Antibody status can be determined by blood testing. Hepatitis B has a long incubation period. HBV vaccination may not prevent HBV infection in individuals who have an unrecognized HBV infection at the time of vaccine administration.

Possible Vaccine Side Effects
The observed incidence of side effects is very low. Injection site reactions consist principally of tenderness and redness. The most frequent systemic complaints include, but are not limited to, fatigue/weakness, headache, fever and malaise. It is not possible to contract hepatitis B from the vaccine since the vaccine is produced synthetically and not from human blood.

Who Should Consider The Vaccine
Vaccination is recommended by the Alabama Department of Public Health and the Centers for Disease Control (CDC) for persons of all ages who are or will be at increased risk of infection with HBV.

Health care workers who have direct clinical patient contact or handle potentially infective materials or items are considered to have an increased risk for contracting hepatitis B.

Contraindication
Vaccination is contraindicated for pregnant or nursing women and for anyone with hypersensitivity to yeast or any component of the vaccine. Persons experiencing hypersensitivity reactions after an injection of the vaccine should not receive further injections.

Student Vaccination
All students entering an Allied Health Department Program at Calhoun Community College are required to provide documented proof of completion of the hepatitis B vaccine series (three injections) or documented proof of immunity to hepatitis B or sign a waiver refusing the hepatitis B vaccination prior to registration for their first Allied Health Department class.

Your private physician can help you decide whether or not you should receive the hepatitis B vaccination series and can further discuss the possible side effects with you. If you decide to receive the hepatitis B vaccination series, you should contact your physician and arrange for its administration. Students are responsible for the full cost of the vaccine and its administration.
The mission of the Physical Therapist Assistant Program is dedicated to the academic and clinical education of individuals who will function as care providers in a multiplicity of settings in which PTAs practice. Implicit in the Program’s curriculum is the development of skills for treatment and therapeutic client interactions.

Based on its mission, the Program’s intent is to educate a competent entry-level physical therapist assistant who can treat the general population of acute and rehabilitation patients in current health care settings. Enrolled students are required to successfully complete both the academic and clinical requirements of the program to receive the AAS degree. The purpose of the following is to delineate the cognitive, affective and psychomotor skills deemed the minimal essential functions necessary for admission, progression, and graduation and for the provision of safe and effective patient care. If a student cannot demonstrate the following skills and abilities, it is the responsibility of the student to request appropriate accommodations through the Office of Disabled Students.

**Cognitive learning skills:** the student must be able to demonstrate the following abilities:

1. Retain and use information in the cognitive, psychomotor, and affective domain in order to treat patients.
2. Perform a physical therapy assessment of a patient’s posture and movement including analysis of physical, biomechanical, and environmental factors in a timely manner, consistent with the acceptable norms of all clinical settings.
3. Use information to execute physical therapy treatment in a timely manner appropriate for the problems identified and consistent with the acceptable norms of all clinical settings.
4. Reassess the treatment plan as needed for effective and efficient management of physical therapy problems in a timely manner, consistent with the acceptable norms of all clinical settings.

**Affective learning skills:** the student must be able to demonstrate the following abilities:

1. Demonstrate appropriate affective behaviors and mental attitudes in order to not jeopardize the emotional, physical, mental, and behavioral safety of patients and other individuals with whom one interact in the academic and clinical setting and to be in compliance with the ethical standards of the American Physical Therapy Association.
2. Cope with the mental and emotional rigors of a demanding educational program in physical therapy that includes academic and clinical components that occur with set time constraints and often concurrently.
3. Acknowledge and respect individual values and opinions in order to foster harmonious working relationships with colleagues, peers and patients.

**Psychomotor skills:** the student must be able to demonstrate the following skills:

1. Sit and maintain upright posture.
2. Stand and maintain upright posture.
3. Locomotion:
   a. Arrive at lecture, lab, and clinical locations in a timely manner
   b. Move within rooms as needed for changing groups, lab partner and work stations, and perform assigned clinical tasks
4. Manual tasks:
   a. Safely maneuver self or move another individuals’ body parts to effectively perform evaluation techniques
   b. Safely maneuver or move clinical equipment from side to side, forward and backward or from a lower to a higher position.
   c. Manipulate common tools used for screening tests of the cranial nerves, sensation, range of motion, and muscle testing procedures (e.g. cotton balls, safety pins, reflex hammer, and goniometer)
   d. Safely and effectively guide, facilitate, inhibit, and resist movement and motor patterns through the use of facilitation and inhibition techniques, including ability to give time urgent verbal and sensory feedback.
   e. Safely move another individual’s body in transfers, gait, positioning, exercise and mobilization technique.
   f. Safely manipulate and move equipment and items to aid in the treatment of a patient (i.e. bolsters, pillows, plinths, mats, gait assistance devices, other supports or chairs, IV’s, monitors, etc)
g. Competently perform CPR using guidelines issued by the American Heart Association or the American Red Cross.

5. Fine motor/hand skills:
   a. Legibly record/document progress notes in standard medical charts in hospital/clinical settings in a timely manner and consistent with the acceptable norms of clinical settings.
   b. Legibly record thoughts for written assessments
   c. Palpate changes in an individual’s muscle tone, soft tissues, skin quality, joint play, kinesthesia, and temperature in a timely manner and sense that individual’s response to environmental changes and treatment
   d. Apply and adjust therapeutic modalities
   e. Apply and effectively position hands to apply soft tissue and mobilization techniques

6. Visual Acuity:
   a. Obtain visual information from clients (e.g. movement, posture, body mechanics and gait pattern)
   b. Obtain visual information from treatment environment (e.g. dials on equipment, assistive devices, furniture placement, and floor surfaces)

7. Communication skills:
   a. Effectively communicate in English with other students, faculty, patients, peers, staff and families to ask questions, explain conditions and procedures, teach home programs, and to maintain safety in a timely manner and within the acceptable norms of academic and clinical settings
   b. Receive and interpret written communication in both academic and clinical settings in a timely manner
   c. Receive and send verbal communication in life threatening situations in a timely manner within acceptable norms of clinical settings

8. Self-care:
   a. Maintain general good health, self-care and hygiene in order not to jeopardize the health and safety of self and individuals with which one interacts in the academic and clinical settings
   b. Arrange transportation and living accommodations for/during off campus clinical assignments to foster timely reporting to the classroom and clinical site.

9. Auditory:
   a. Effectively auscultate lungs, apical pulse, and blood pressure.

I have reviewed the Essential Functions for this program and I certify that to the best of my knowledge – I currently have the ability to fully perform these functions

_________________________________________________ ________________________________
Student Signature Date