Phlebotomy Certification Program
REPORT OF HEALTH STATUS EVALUATION

To the student: Completion of ***all*** sections, A through D, of the health form is required for students participating in the Phlebotomy training program. These requirements are necessary for you to participate in the clinical experience. Students ***born before 1956 are not exempt*** from proof of immunization or titers for rubella and rubeola.

DIRECTIONS FOR COMPLETING THE HEALTH FORM: The student completes sections A & B of the health form. Your physician completes sections C & D.

PLEASE PRINT LEGIBLY OR TYPE ALL RESPONSES

SECTION A: BIOGRAPHICAL INFORMATION - TO BE COMPLETED BY THE STUDENT

_____
Last Name, First, Middle Initial

_____
Home Address

_____
Town/City State Zip

Preferred Phone Number_____

Date of Birth: _____ Gender: _____

Social Security: _____ Health Insurance _____
(please attach a copy of insurance card)

Marital Status: _____

PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY:

_____
Name

_____
Address

_____
Preferred Telephone Number

_____
Work Telephone Number

SECTION B: PERSONAL HEALTH HISTORY - TO BE COMPLETED BY THE STUDENT

Have you had or do you now have any of the following health problems?

	YES	NO	EXPLAIN
1. SKIN			
Chronic skin disease	____	____	_____
Other abnormalities	____	____	_____
2. HEAD			
Concussion	____	____	_____
Frequent headaches/Migraines	____	____	_____
3. EYES			
Your last vision examination?	____	____	_____
Do you require corrective lenses?	____	____	_____
4. EARS			
Hearing difficulty/deafness.	____	____	_____
Other abnormalities	____	____	_____
5. NOSE, MOUTH, & THROAT			
Loss of smell	____	____	_____
Other abnormalities	____	____	_____
6. RESPIRATORY			
Tuberculosis	____	____	_____
Chronic Lung Disorder	____	____	_____
Asthma	____	____	_____
Allergies	____	____	_____
7. CARDIOVASCULAR			
Heart Disease	____	____	_____
High Blood Pressure	____	____	_____
8. MUSCULO SKELETAL			
Joint pain or joint problems	____	____	_____
Back Trouble	____	____	_____
Mobility Limitations	____	____	_____
Paralysis	____	____	_____
9. HEMATOPOIETIC			
Blood disorders	____	____	_____

	YES	NO	EXPLAIN

10. MENTAL HEALTH

Have you received treatment for mental health concerns	____	____	_____

11. OTHER

Allergies to Medications (Specify - briefly describe)	____	____	_____
Hospitalizations (briefly describe)	____	____	_____ _____ _____
Operations (briefly describe)	____	____	_____ _____
Do you take any prescription or non-prescription medications regularly (specify)	____	____	_____

12. How would you describe your overall health?

Section C: Immunization Requirements

Phlebotomy Certification Program

The following form must be completed and signed by a Medical Provider. The University of Maine System and Maine State Law require that the following be completed.

(Please print legibly)

Student's Name _____ Date of Birth _____ Social Security # _____

STUDENTS MUST HAVE:

1. Diphtheria-Tetanus Booster within the last 10 years. Date: _____

2. MMR (Rubeola, Rubella, and Mumps) –*First dose must be after first birthday*
   Date of first dose: _____
   Date of second dose (required): _____
   OR split series:

   Rubella Vaccine: _____ (Date) or Titer _____ (Date) _____ (Results)
   Rubeola Vaccine: _____ (Date) or Titer _____ (Date) _____ (Results)
   Mumps Vaccine: _____ (Date) or Titer _____ (Date) _____ (Results)

3. Hepatitis B Series **(strongly recommended)**
   Injection 1 _____ (Date) Injection 2 _____ (Date) Injection 3 _____ (Date)
   Titer Results: _____ (Date) _____ (Results)

4. Varicella Titer _____ (Date) _____ (Results)
   If titer negative (not immune) varivax injections required

   Varivax 1 _____ (Date) Varivax 2 _____ (Date)

5. Tuberculin Test (PPD)
   STEP 1:
   Type _____ Date Administered _____ Signature _____
   Date Read _____ Results _____ Signature _____
   STEP 2:
   Type _____ Date Administered _____ Signature _____
   Date Read _____ Results _____ Signature _____

_____
Signature of Physician/Health Care Professional

_____ _____
Name (Please print or type) Telephone No.

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SECTION D: PHYSICAL EXAMINATION
TO BE COMPLETED BY THE PHYSICIAN/HEALTH PROFESSIONAL

TO THE PHYSICIAN: Please review the historical information that has been provided and complete this physical examination form, commenting on any positive findings. This information is kept confidential and will not jeopardize the student's enrollment status. Once completed please return to the student.

_____

(STUDENT) Last Name, First, M.I.

_____

Address City, State Zip Code

Are there abnormalities of the following systems:

	YES	NO	REMARK
Skin	____	____	_____
Head	____	____	_____
Eyes	____	____	_____
Ears, Nose, Mouth, Throat	____	____	_____
Respiratory	____	____	_____
Cardiovascular	____	____	_____
Gastrointestinal	____	____	_____
Genitourinary	____	____	_____
Mental Health	____	____	_____
Metabolic/Endocrine	____	____	_____
Musculoskeletal	____	____	_____
Neurological	____	____	_____

Recommendations for physical activity:

Limited? _____ Explain:_____

Unlimited? _____

Does the student require any medications (prescription or non-prescription) on a daily or regular basis?

YES_____ NO_____ (IF YES, SPECIFY) _____

Additional Remarks: Attach additional sheets as needed to describe any positive findings and/or clarify any information.

_____ Date: _____

Physician/Health Professional Signature

_____ Phone: _____

Address