Coral Springs Regional Institute of Public Safety

"Commitment to Excellence"

Patient Name:	**DOB:**	**Age:**	**Sex:**	**Exam Date:**

Does Patient have a Significant Past Medical History? ☐ NO ☐ YES, Comment: _____
Current Medications Reviewed? ☐ NONE ☐ YES, Comment: _____

Vital Signs:	Blood Pressure	Pulse	Resp.	Temp.	Height	Weight

Please check "Normal" or "Abnormal" after each entry and make comments if necessary.

System Checked	***Normal***	***Abnormal***	***Comments:***	***System Checked***	***Normal***	***Abnormal***	***Comments:***
Head, Eyes, Ears, Nose	☐	☐		Abdomen	☐	☐	
Throat, Neck, Thyroid Gland	☐	☐		Skin	☐	☐	
Thorax, Lungs/Heart	☐	☐		Neurological/Mental Status	☐	☐	
Extremities/Spine	☐	☐					

☐ PPD/TB – Date Given: _____ M.A. Initials: _____
Date of Results (48-72 hrs.): _____ ☐ Negative ☐ Positive (>10mm) MD Initials: _____
☐ (If Positive PPD) Chest X-Ray – Date Taken: _____ Results: ☐ Negative ☐Other: _____ Provider Initials: _____

(NOTE: The DH 680 (BLUE form) can be provided as proof of immunity for the below) ☐ Check if attached

Vaccine:	**Date Given:**	**Or Titer Results**
▪ Mumps		If titers, please upload results paperwork
▪ Rubeola		If titers, please upload results paperwork
▪ Rubella (German Measles)		If titers, please upload results paperwork
OR MMR (requires 2 doses)		If titers, please upload results paperwork
▪ Varicella		If titers, please upload results paperwork
▪ Influenza (Oct – April)		
▪ Tdap		

***CONSENT TO HEPATITIS B VACCINATION**

I consent to administration of the hepatitis B vaccine. I have been informed of the method of administration, the risks, complications and expected benefits of the vaccine. It is my responsibility to obtain all 3 doses of the vaccine. I have thoroughly read the aforementioned handout regarding the risks and contraindications of the vaccine and agree to release and hold harmless MD Now Medical Centers, Inc.,

☐ **I consent to the 3 Hepatitis B Vaccine Injections** 1st DOSE: _____ 2nd DOSE: _____ 3rd DOSE: _____

***DECLINE HEPATITIS B VACCINATION**

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. I have been given the opportunity to be vaccinated with hepatitis B vaccine; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. By declining the hepatitis B vaccine at this time I agree to hold harmless MD Now Medical Centers, Inc., their staff and all its agents.

☐ **I decline the 3 Hepatitis B Vaccine Injections**

_____ _____ _____
Patient Signature Witness Signature Date

☐ **Referral and/or Follow Up Advised.** (Please refer to patient's chart for more specific details)

☐ I have found this student to be physically qualified having no current major health issue that would limit them from performing any CSRIPS clinical externship duties, and found them **free of known communicable disease.**

_____ _____ _____
Practitioner's Signature Practitioner's Stamp Date

MEDICAL RECORD RELEASE FORM: I hereby authorize the release of the information documented on the above form to the ***CSRIPS*** for the sole use of a general work physical and/or drug screen test:

_____ _____
Patient Signature Date

MEDICAL HISTORY AND PHYSICAL EXAMINATION FORMS

1. As part of the application process, a medical history and physical examination are required for all students. Medical records must be complete in order for a student to be allowed to participate in the clinical portion of the Program.
2. Physical exams, required Immunizations and/or Titers, TB test and/or Chest X-ray must be taken and updated every 6 months, or as required by the Program.
3. The student must provide all of the information requested on this package. The following pages are to be completed by the Examiner/Physician.
4. It is the student's responsibility to turn in the completed medical history, and all of the required supporting documents, to the Coral Springs Regional Institute of Public Safety.
5. If you have had a complete physical exam within the past year, you must have the physician transfer the information to this medical history form.
6. Falsifying any information on these forms is cause for dismissal from the Program.

To be filled out by the student – Please print clearly

Name: _____

Last First Middle

Address: _____

Street City State Zip

Home Phone: _____ Work Phone: _____

Have you had/Do you have	Yes	No	If yes, please comment
Hay Fever			
Hepatitis A			
Hepatitis B			
High Blood Pressure			
Dizziness or Fainting			
Rheumatic Fever/Heart Murmur			
Convulsion/Epilepsy			
Diabetes			
Disease/Injury of Joints			
Back Problems			
Physical Limitations			
Additional comments			