NIAGARA COUNTY COMMUNITY COLLEGE

WELLNESS CENTER

MASSAGE THERAPY STUDENT CHECKLIST

**IMPORTANT**

Submit the Massage Therapy Student Checklist **with** the NCCC “Physician’s Physical for Clinical Rotations” to the Wellness Center (**C-122**) via mail.

* Forms will only be accepted by the Wellness Center after **ALL** items on both

 **Part I** and **Part II** of the checklist have been completed.

**PLEASE NOTE:**

1. **The NCCC** “Physician’s Physical for Clinical Rotations” forms will be the **only** form accepted.
2. **Initial** the paragraphs on the front of the form **after** reading and agreeing with the

 contents. Sign and date the box on the first page with a witness at your Provider’s office if

possible.

1. Please follow instructions contained in the additional form provided to you for all Allied Health students during the pandemic.
2. Students are **not permitted** to write on the Physician pages, with the only exception being if signing the Hepatitis Declination Statement (back page).
	* **Student sections** are the first page and top area of the second page
	* **Physician pages** are the lower area on the second page, entire third page and last page

*\*Please make* ***hard copies*** *of all forms for your records* ***prior*** *to submitting them to the Wellness Center, if possible.*

 *\*\** ***Note:*** *It is* ***your*** *responsibility to provide documentation to facilities requesting your information.*

\*\*\*If you have questions or require assistance, please feel free to contact the ***Wellness Center at***

 ***(716) 614-6275*** and ask to speak to a ***Nurse.***

4-8-2020

**STUDENT CHECKLIST**

**Place an “X” in the boxes after completing each item.**

**PART I :**

**Student Pages:**

**First Page:**

* 1. Prior to submission of form, **read the front page**
* Initial all paragraphs
* Sign/Date form with witness

**Top of Second Page:**

* 2. Student ID number
* 3. Student name, address, date of birth and phone
* 4. Allergies
* 5. Explain Allergies
* 6. Latex Allergy/Symptoms
* 7. Limitations
* 8. Explain Limitations
* 9. Emergency contact name, relationship, phone numbers
* 10. Signature/Date

**PART II:**

**Physician’s Pages:**

 **\*\* *Before leaving the* *doctor’s office, be sure these sections of the checklist are* co*mplete.***

**Bottom of Second Page:**

* 1. Height
* 2. Weight
* 3. Blood Pressure
* 4. Pulse
* 5. Personal medical history – check all that apply; **Provide explanation**
* 6. **Each box of physical exam is addressed**

**Third Page:**

⁬ 7. Student Name

⁬ 8. Student Date of Birth

⁬ 9. Evidence of anxiety/problems requiring treatment

⁬ 10. Physical/emotional problems to be followed in college

⁬ 11. Medications (Prescription and Over the Counter)

⁬ 12. Reason/Condition for Medications

⁬ 13. Pregnant/EDD

⁬ 14. Allergies with Explanation

⁬ 15. Professional opinion regarding **physical demands** – BOTH Capable & Restrictions

⁬ 16. Professional opinionregarding **emotional demands** - BOTH Capable & Restrictions

⁬ 17. Explanation of Restrictions/Limitations

⁬ 18. Health care provider:

⁬ - Signature

⁬ - Date

⁬ - Stamp with address and phone

**Fourth (Last)Page:**

⁬ 19. Name, Date of Birth

⁬ 20. Proof of immunity to Measles, Mumps and Rubella

⁬ 21. Tetanus/Diphtheria (**Tdap** recommended if update is needed)

⁬ 22. Tuberculosis (TB) screening:

 A. Signs of active TB

 B. History of BCG

 C. **Two (2)-Step TB skin test *(Refer to Massage Therapy Student Memo #4)***

 **\*\****If provided separately -- Must state:* ***Date Given, Date Read, Results in mm,***

 ***and MD/PA/NP/RN signature***

 **\*\**\**Note: TST readings by an LPN are NOT acceptable\*\*\***

 D. Chest x-ray: Required if tuberculin skin test is positive -- (**Attach Copy of Report)**

 E. Treatment plan if indicated

⁬ 23. Chicken Pox:

⁬ A. Disease history

 **AND**

⁬ B. Varicella titer (**Attach Copy of Report)**

Titer is Mandatory Regardless of Chicken Pox History

 **OR**

⁬ C. Two (2) Varicella immunizations

⁬ 24. Hepatitis B: (3 dose series)

⁬ A. Vaccination dates

⁬ B. Titer: Hepatitis B Surface Antibody, **Quantitative** – (**Attach Copy of Report)**

 **OR**

⁬ C. Declination statement (student signature and date)

⁬ 25. Health care provider:

⁬ - Signature

⁬ - Date

⁬ - Stamp with address and phone