NIAGARA COUNTY COMMUNITY COLLEGE

WELLNESS CENTER

MEDICAL ASSISTANT/PHLEBOTOMIST STUDENT CHECKLIST

**IMPORTANT**

Submit the Medical Assistant/Phlebotomist 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 the 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 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 first 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. **TB skin test** (***Refer to Med Asst/Phleb Student Memo #4)***

TB Skin Test (TST) is required with the **initial physical** and is then updated on an

**annual** basis

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

***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

**OR**

⁬ 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