COLLEGE of CENTRAL FLORIDA
–an equal opportunity college–

HEALTH INFORMATION TECHNOLOGY
HEALTH CERTIFICATE

STUDENT NAME: _____ **SEMESTER:** _____

Directions: Your physical must be completed by a physician, ARNP, PA or DO. All sections of both sides of this form must be completed and any requested information attached. You will need to have a drug screen. Your immunizations can be procured from your healthcare provider, a health department, or some walk-in facilities. You may need to make an appointment.

REQUIREMENTS FOR HEALTH INFORMATION TECHNOLOGY STUDENTS

Participants in the Health Information Management Program are required to:

- Walk the equivalent of 5 miles per day
- Grip, reach above shoulder level, bend at the knee, squat, stoop and crawl
- Sit or stand for prolonged periods of time
- Lift a minimum of 10 pounds
- Manipulate paper dexterously
- Cope with a high level of stress
- Prioritize
- Distinguish colors
- Concentrate
- Be flexible and self-directed
- Problem solve
- Demonstrate a high degree of patience
- Communicate clearly and correctly in writing and verbally

STUDENT: COMPLETE AND SIGN THE FOLLOWING:

STUDENT NAME: _____
Last First Middle (complete) Jr., etc.

ADDRESS: _____
Street/P.O. Box City State Zip Code

TELEPHONE: _____

GENERAL HEALTH

If you have ever been hospitalized, state dates and reasons. If not applicable, write "NA".

Identify any past or present health problems, including chronic illnesses (physical, mental or emotional) and infectious diseases, and current treatment. If not applicable, please write "none" in each category.

Physical:

Mental/Emotional:

Infectious Diseases:

I am aware of the physical and emotional requirements listed above, and to the best of my knowledge, I am emotionally and physically capable of complete participation in the Health Information Management Program. I certify that all of the information provided by me is accurate and complete.

Student Signature _____ Date: MM/DD/YY

IMMUNIZATIONS: The following immunizations and/or testing are required. It is your responsibility that these remain current during the course of the program.

You may either attach a copy of the current immunization record and results of the drug screen, signed by the health care provider, to this Health Certificate or the health care provider may complete the section below and date and sign to verify immunizations and/or testing.

REQUIRED IMMUNIZATIONS

T.D. (Tetanus/Diphtheria) within 10 years or within two years if injured

PPD (Tuberculin) good for one year

Students with a positive TB test must be found free of active TB via a baseline chest x-ray. Each year following the initial testing, the individual must be certified to be free of the signs and symptoms characteristic of active TB. The provider's signature indicates the individual with a positive TB test is free of these signs and symptoms.

MMR (Measles, Mumps, Rubella, Rubeola) or titer

CHICKEN POX (Verify that you have had, or provide titer verifying you have had, or have the immunization series.)

DATE OF IMMUNIZATION/TEST/DRUG SCREEN		**RESULT**
T.D.		
PPD		
MMR		
CHICKEN POX		
DRUG SCREEN		

HEALTH CARE PROVIDER:

I am aware of the physical and emotional requirements listed in the foregoing under Requirements for Health Information Management students and, after a complete examination, I certify that this individual is physically and emotionally capable of participation in this program, including in the practicums, without limitations.

Please print name of provider /credentials (MD, DO, ARNP, PA)

Signature of Provider

ADDRESS: _____ **TELEPHONE:** _____

HEPATITIS B VACCINATION: (You must check one of the responses below and sign.)

☐ I have received the series of injections for Hepatitis B vaccination. (Attach proof).

☐ I am in the process of receiving the series of injections and will provide proof upon completion.

☐ I understand that, because of occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I understand to protect myself I need to be vaccinated with the Hepatitis B vaccine. However, I decline the 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. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series.

Signature of Student

Date: MM/DD/YY