HEALTH CENTER
MEDICAL RECORD

Medical records are confidential and are kept under secure conditions. They are used only by authorized personnel for the purpose of furnishing counseling service and assistance.

NAME _____
Last First Middle Former

ADDRESS_____
No. Street City State Zip Code

HOME TELEPHONE NO: _____DATE OF BIRTH_____SOC. SEC. NO._____

IN CASE OF EMERGENCY NOTIFY:_____PHONE:_____

PERSONAL HISTORY
CHECK AND DESCRIBE BELOW:

CONDITION	YES	NO	CONDITION	YES	NO
ALERGIES			**HEART**		
ASTHMA			**INJURIES**		
CANCER, CYSTS, TUMOR, ETC.			**KIDNEY**		
CONVULSIONS OR EPILEPSY			**MUSCULO-SKELETAL**		
DIABETES			**NERVOUS**		
DRUG HABIT			**RHEUMATIC FEVER**		
EARS			**THYROID**		
EYES			**TUBERCULOSIS**		
FAINTING			**VENEREAL DISEASE**		
GASTRO-NTESTNAL					

1. DESCRIBE ANY ITEM CHECKED YES: _____
_____

2. LIST ANY PREVIOUS SERIOUS ILLNESSES AND OPERATIONS: _____
_____/DATE _____

CHECK BOX IF ANY PHYSICAL HANDICAPS:

A. ☐ WHEELCHAIR BOUND
B. ☐ BLIND OR PARTIALLY SIGHTED
C. ☐ USE BRACES AND CRUTCHES
E. ☐ NEUROLOGICAL IMPAIRMENTS (POLIO, CEREBRAL PALSY, ETC.)
F. ☐ SPEECH IMPEDIMENTS
G. ☐ OTHERS – DESCRIBE: _____

_____

DESCRIBE DISABILITY BRIEFLY: _____

_____

PHYSICAL EXAMINATION

(TO BE COMPLETED BY A LICENSED PHYSICIAN)

HEIGHT_____IN. WEIGHT_____LBS. VISION O.D. _____ CORR. _____ TUBERCULIN PPD (MANTOUX TEST). DATE____ RESULT_____

O.S.___ CORR.____CHEST XRAY: DATE: _____ _____RESULT____
Month Year

B.P. _____/ _____mmHg. PULSE_____/min.

Hgb. _____Gm.%

NORMAL	ABNORMAL		REMARKS – DESCRIBE ABNORMALITIES ONLY
		HEAD & NECK	
		NOSE AND SINUESE	
		MOUTH AND THROAT	
		GUMS AND TEETH	
		EYES	
		EARS, HEARNG	
		CHEST, BREASTS, LUNGS	
		HEART	
		VASCULAR SYSTEM	
		ABDOMEN AND VISCERA	
		HERNIA	
		ANUS AND RECTUM	
		SPINE AND MUSCULOSKELETAL	
		GENITO-URNARY SYSTEM	
		SPINE AND MUSCULOSKELETAL	
		SKIN-IDENTIFYING MARKS, SCARS, TATTOOS	
		NEUROLOGIC	
		PSYCHIATRIC	

IS THERE ANY EMOTIONAL, MENTAL OR PHYSICAL CONDITION FOR WHICH THIS STUDENT IS UNDER MEDICAL OBSERVATION AND/OR TAKING MEDICATION: ☐ YES ☐ NO
SPECIFY:

PHYSICIAN'S NAME (PRINT) _____

SIGNATURE _____

ADDRESS _____

DATE OF EXAMINATION: _____

ATTENTION: NURSING, SURGICAL TECH, EMS, PARAMEDIC, PSG FACULTY
Pursuant to section 405.3 (b) of the New York State Hospital Codes, the following Statements of Physical Examination is required:

I have examined_____on_____

Based on my physical examination and the patient's medical history, I believe that the above-referenced is free from a health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

_____
Physician's signature License number (PHYSICIAN'S STAMP)

KINGSBOROUGH COMMUNITY COLLEGE
2001 ORIENTAL BOULEVARD
BROOKLYN, NEW YORK 11235

Health Center

HEALTH REQUIREMENT FOR SURGICAL TECH / EMS / PSG

PLEASE MAKE (3) COPIES OF ALL MATERIALS

Faculty in the clinical phase of the Surgical Tech, EMS, and Paramedic programs must complete ALL of the following requirements as indicated and bring them to the Health Center, Room A108.

DEADLINE DATE: _____

Student's Name: _____ S.S. #: _____

_____ **1. Complete physical done by a private physician**

_____ **2. Urinalysis and drug screen 10 panel with lab results**

_____ **3. 2 step PPD/Quantiferon Blood Test**

_____ **4. TDAP** **Date:** _____

_____ **5. Hepatitis B Immunization**
1st Date: _____ 2nd Date: _____ 3rd Date: _____
or Declination if the series is incomplete

_____ **5a Hepatitis HbsAB Titer – lab report required**
Hepatitis HbsAG Titer – lab report required

_____ **6. Hepatitis C antibody**

_____ **7. Serology (VDRL) lab report required**

_____ **8. Complete blood count (CBC)**

_____ **9. Varicella titer - lab report required**

_____ **10. Rubeola (measles) titer - lab report required**

_____ **11. Rubella (German measles) titer - lab report required**

_____ **12. Mumps titer - lab report required**

_____ **13. Flu vaccination**

Physician's Stamp: _____ **Date:** _____

NEW CLINICAL SURGICAL TECH / EMS / PARAMEDIC / PSG

PPD Placed _____Site: _____Lot #: _____Brand: _____By: _____
(date) (signature)

Results:_____mm induration Date:_____ Signature: _____
_____ License #_____

PPD Booster: Placed: _____Site: _____Lot #: _____Brand: _____ By: _____
(date) (signature)

Results: _____ mm induration Date: _____ Signature:_____
License # _____

Booster must be placed between 1 and 3 weeks

CHEST X-RAY: DATE: _____ RESULTS: _____

Quantiferon Blood Test Acceptable in place of 2 Step PPD.

KINGSBOROUGH COMMUNITY COLLEGE
2001 ORIENTAL BOULEVARD
BROOKLYN, NEW YORK 11235

Health Center

HEALTH REQUIREMENTS FOR RETURNING CLINICAL SURGICAL TECH/EMS/PSG FACULTY

PLEASE MAKE (3) COPIES OF ALL INFORMATION SUBMITTED

Faculty in the clinical phase of these Programs must complete ALL of the following requirements as indicated and bring them to the Health Center – Room A108.

DEADLINE DATE: _____

Name: _____ Emplid #: _____

_____ **1. Complete physical done by a private physician required annually**

_____ **2. Urinalysis and drug screen – lab report required**

_____ 3. **Tuberculin Test – required annually**
Mantoux Skin Test – Date: _____ Result: _____
Chest X-Ray (only if positive skin test) – Date: _____ Result:_____

_____ **4. Complete blood count (w/differential) - lab report required**

Physician's Signature: _____ Physician's Stamp:

Date: _____

Revised 5/2025