

**ALVIN COMMUNITY COLLEGE DEPARTMENT OF CONTINUING EDUCATION**

3110 MUSTANG ROAD

ALVIN, TX 77511-4898

Phone: 281-756-3789 \* Fax: 281-756-3952 \* Email: [ce@alvincollege.edu](mailto:ce@alvincollege.edu)

**PHYSICAL EXAM FORM**

<b>Health Program</b>	<b>Phlebotomy Program</b>
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Student Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

*NOTE: While confidentiality of this information will be maintained, full health information is necessary for the student's protection as well as that of others.*

**1. Medical History: (To be completed by Student)**

Please identify any of the following for which you have received medical treatment within the past five years:

Rheumatic fever	Menstrual disorders	Joint disease
Back injuries	Epilepsy	Cardiovascular disease
Hay fever	Diabetes	Sinusitis
Frequent colds	Tuberculosis	Thyroid disease
Anemia	Asthma	Ulcer/colitis
Hypertension	Frequent headache	Other (please describe)

Please list (with dates if possible)

1. Chronic illnesses \_\_\_\_\_
2. Current medications \_\_\_\_\_
3. Physical limitations \_\_\_\_\_
4. Currently pregnant\* \_\_\_\_\_

*\*If yes, must provide Physician's release*

**2. Physical Examination: (To be completed by Primary Care Provider)**

The Primary Care Provider is requested to make a complete physical examination of the student and note any deviations from normal.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ B/P \_\_\_\_\_

Condition of:

SYSTEM	NORMAL	ABNORMAL	COMMENTS	SYSTEM	NORMAL	ABNORMAL	COMMENTS
skin				heart			
eyes				abdomen			
ENT				reflexes			
neck				musculoskeletal			
lungs							

Describe any abnormal findings: \_\_\_\_\_

I examined \_\_\_\_\_ (Student Name) (student name) on this date and found him/her to be in \_\_\_\_\_ health.

\_\_\_\_\_  
Primary Care Provider's Name (Please Print)

\_\_\_\_\_  
Primary Care Provider's Signature (Please sign)

\_\_\_\_\_  
Office Address (Street)

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Date

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**IMMUNIZATION RECORD**

<b>Health Program</b>	<b>Phlebotomy Program</b>
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Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Tuberculosis Screening.** Skin test **OR** Chest x-ray (if skin test is positive). Must be within 12 months prior to start of course.

TB Test Date:	Date Read:
Chest x-ray date:	Results:

**Immunizations** – The Texas Dept. of Health requires the following immunizations for students enrolled in health related courses:

- Measles, Mumps, and Rubella (German Measles) (all students born after 1956)**  
1 dose measles, mumps, AND Rubella vaccine administered on or after 1<sup>st</sup> birthday **OR** serologic confirmation of immunity
- Tetanus/Diphtheria (all students)**  
1 dose TD within past 10 years (mo/day/yr must be recorded)
- Varicella (Chicken Pox) (all students)**  
2 doses of Varicella vaccine on or after 1<sup>st</sup> birthday **OR** immunity verified by student/parent/physician **OR** serologic confirmation of immunity
- Hepatitis B** series of three immunizations **OR** serologic confirmation of immunity

Date (mm/dd/yr)	Vaccine	Validation Signature/Stamp
	MMR (measles, mumps, rubella)	
	T/D (Tetanus/Diphtheria)	
	Hepatitis B (3 doses)	
	Varicella (Chickenpox) /Date of Disease	Must complete statement below

I, \_\_\_\_\_ hereby state that all information provided above is true and  
 (Print Name)

accurate to the best of my knowledge.

\_\_\_\_\_  
 (Signature) (Date)

**Phlebotomy Student Application**  
Alvin Community College Continuing Education  
APPLICATION FOR COURSE ADMISSION

NAME \_\_\_\_\_

SOC SEC# \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(Street) (State) (Zip Code)

PHONE ( ) \_\_\_\_\_ ALTERNATE PHONE ( ) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_  
(Name) (Relationship) (Phone #)

CURRENTLY EMPLOYED: \_\_\_\_\_

WORK HOURS/WEEK (OUTSIDE HOME) DURING COURSE? \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF A FELONY? \_\_\_\_\_ (IF YES, PLEASE CONTACT DIRECTOR OF CNA PROGRAM.)

EMAIL ADDRESS (OPTIONAL) \_\_\_\_\_

I, \_\_\_\_\_, HEREBY STATE THAT ALL INFORMATION  
(Print Name)

PROVIDED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**STUDENTS WITH DISABILITIES**

This college adheres to all applicable federal, state, and local laws, regulations, and guidelines with respect to providing reasonable accommodations as required affording equal educational opportunity. ACC provides reasonable accommodations for qualified individuals who are students with disabilities. It is the student's responsibility to contact the Counseling Center in a timely manner to arrange for appropriate accommodations. Once the disability is identified, please notify your Instructor for additional modifications.

