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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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| **Instructions to Health Provider:** | | |  | |  | |  | |  | |  | |  | |  |  |  |  |  |  |
| The Student named below has applied to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ program with OMCC and needs to submit documentation of fitness for duty and a statement indicating he/she is free from potentially communicable disease(s). | | | | | | | | | | | | | | | | | | | | |
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|  | | |  | | | |  | |  | |  | |  | |  |  |  |  |  |  |
| Student Name |  | |  | |  | |  | | Sex | | Date of Birth | |  | |  |  |  |  |  |  |
|  |  | |  | |  | |  | |  | |  | |  | |  |  |  |  |  |  |
| **PHYSICAL/VITAL SIGNS** | | | I have examined and certify that he/she is medically capable of performing | | | | | | | | | |  | |  |  |  |  |  |  |
|  | | | his/her presented duties. | | | |  | |  | |  | |  | |  |  |  |  |  |  |
| Temperature |  | |  | |  | |  | |  | |  | |  | |  |  |  |  |  |  |
| Pulse |  | |  | |  | |  | |  | |  | |  | |  |  |  |  |  |  |
| Respiratory Rate |  | |  | | Physician/Clinic Signature | | | |  | | Date | |  | |  |  |  |  |  |  |
| Blood Pressure |  | |  | | | |  | |  | | | |  | |  |  |  |  |  |  |
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|  | | | **TUBERCULOSIS (TB) PPD TESTING** | | | | | | | | | |  | |  |  | |  |  |  |
| |  | | --- | | ***\* Note: Chest X-Ray***  A positive TB result with the two-step Mantoux test necessitates a Chest X-Ray    Chest X-Ray: (Attach a copy of report)  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **1st Step ↓** | | | | Good for 1 Year | | **2nd Step ↓** | | | |  | |  |  | |  |  |  |
|  | | | *Read in 48 - 72 Hours* | | | |  | | *Applied 7 - 21 days after 1st Step* | | | |  | |  |  | |  |  |  |
|  |  | |  | | | | Date Applied | |  | | | |  | |  |  |  |  |  |  |
|  | | |  | | | | Site | |  | | | |  | |  |  | |  |  |  |
|  | | |  | | | | Signature | |  | | | |  | |  |  | |  |  |  |
|  |  | |  | | | | Lot # | |  | | | |  | |  |  |  |  |  |  |
|  |  | |  | | | | Date Read | |  | | | |  | |  |  |  |  |  |  |
|  |  | |  | | | | Signature | |  | | | |  | |  |  |  |  |  |  |
|  |  | |  | | | | Results (mm) | |  | | | |  | |  |  |  |  |  |  |
|  |  | |  | |  | |  | |  | |  | |  | |  |  |  |  |  |  |
| **IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE STUDENT IS FREE FROM ACTIVE TUBERCULOSIS DISEASE** | | | | | | | | | | | | |  | |  |  |  |  |  |  |
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| **PRE-CLASS HEALTH STATEMENT** | | | | | | | | | | | | |  | |  |  |  |  |  |  |
|  |  | |  | |  | |  | |  | |  | |  | |  |  |  |  |  |  |
| I certify that I am free of any lower back ailments, communicable disease, pregnancy limitations, or any other ailments that could prevent me from performing my duties in a satisfactory manner. | | | | | | | | | | | | |  | |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |
|  | | |  | | | |  | |  | |  | |  | |  |  |  |  |  |  |
| **Student Signature** |  | |  | |  | |  | | **Date** | |  | |  | |  |  |  |  |  |  |
|  |  | |  | |  | |  | |  | |  | |  | |  |  |  |  |  |  |