

Phlebotomy Technician Training Program Medical Form

Name of Person Examined

DOB

I. TESTS (See Attached Physical Exam and Healthcare Student Immunization Form)

II. FINDINGS

Summary of health problems or conditions, if any, that may affect the student's ability to perform the duties of a Phlebotomist.

III. RECOMMENDATIONS

The above individual was found free from symptoms of communicable disease, able to lift a minimum of 25 lbs. unassisted and otherwise physically and emotionally fit to perform the duties of a Phlebotomist without restriction.

_____ Yes _____ No If "No", explain _____

Date

Physician's Signature

Physician's State License Number

Physician's Address: _____

Physician's Phone: _____

McHenry County College Physical Examination – Phlebotomy Students

Date:		Sex:	
Name:		DOB	
Address			
Home Phone		Cell Phone:	
Family Physician			
Height:			
Weight:			
Skin Diseases:			
Orthopedic:			
Neurological:			
Eyes:	Acuity	2/20	
	Disease		
Ears	Hearing		
	Disease		
Heart	Murmur		
	Disease		
Nose, Throat, Sinuses			
Tonsils, Adenoids			
Glands			
Blood Pressure			
Pulse			
Lungs			
Hernia			
Dental Attention Needed			
Under Dental Treatment			

Doctors Notes: (Use additional page if necessary)

Note to Physician: This form is merely a guideline for your use. This student needs to meet physical exam criteria as established by you, the examining Physician, for participation in a physically, emotionally and intellectually rigorous phlebotomy program. The exam must be administered by a qualified health care professionally licensed to administer physical examinations. The above named student is here by certified for participation in McHenry County College Phlebotomy Training Program without limitations.

HEALTHCARE STUDENT IMMUNIZATION FORM

Name: _____ DOB: _____ Date: _____

Vaccine	Date	Date	Date	Titer/Date	Disease	Provider Initials
Measles (Rubeola)				Immune: Yes ___ No ___		
Mumps				Immune: Yes ___ No ___		
Rubella				Immune: Yes ___ No ___		
Varicella (Chicken Pox)				Immune: Yes ___ No ___		
Hepatitis B				Immune: Yes ___ No ___		
Tetanus, Diphtheria, and Pertussis (TdaP) Within 10 years						
2 Step Mantoux TB Test or Chest X-Ray in(+) reactor Within 1 year						
Influenza, current year						

Immunizations complete: Yes/Date: _____

No/needs the following: _____

Dates Completed: _____

Physician's Signature: _____

Physician's Phone: _____

EMERGENCY MEDICAL INFORMATION

STUDENT INFORMATION

Student's Name: _____

Gender: _____ Date of Birth: _____ Social Security #: XXX-XX-_____

Address: _____

City/State: _____ Zip Code: _____

Phone #: (_____) _____ - _____

HEALTH INSURANCE INFORMATION

Insurance Carrier: _____

Policy Holder's Name: _____ Relationship: _____

Policy I.D. #: _____ Group #: _____

EMERGENCY CONTACTS

Name: _____ Phone #: (_____) _____ - _____

Name: _____ Phone #: (_____) _____ - _____

List any allergies, medications or health conditions that may be pertinent for emergency treatment.

1. _____

2. _____

3. _____

Student's Name: _____ ID Number: _____
(Print)

Student's Signature: _____ Date: _____

ACKNOWLEDGMENT FORM

By Initialing each line signifies that I have read and comprehend the Phlebotomy Technician Training Handbook.

I have a copy of the Phlebotomy Student Handbook and understand that I am responsible for knowing the contents. _____

I agree to abide by the policies and Code of Ethics of the PBT/Phlebotomy program. _____

I am aware of the phlebotomy program completion requirements which include successful completion of 66 hours of classroom theory and practical. _____

- I am aware of the clinical practicum placement policies and procedures; i.e.
 - *I am required to successfully complete 30 Venipunctures and 10 Capillary sticks on order to qualify to take the National Healthcareers (NHA) Certification exam*

- I will have met or will meet the Health and Immunization requirements prior to the start date. _____

- I am aware that MCC will not assume the cost of treatment or care for injury or any medical condition occurring during my student laboratory classes. _____

- I am aware of the confidentiality requirements (patient and medical records) and will abide by them. _____

- I certify that I understand the MCC Phlebotomy Program's Essential Functions requirements and that I meet each one. _____

- I have had an opportunity to ask questions about this material and have had those questions answered to my satisfaction. _____

- I agree that while enrolled in the Phlebotomy Program I will treat my studies and labs as an employee would treat job responsibilities, recognizing that my instructor assumes the role of my supervisor. I will attempt to learn not only the technical skills, but will also strive to develop a professional manner and attitude. _____

- I understand that if a student misses 9 hours over the duration of the program they are advised to withdraw and will be administratively withdrawn from the program without a refund. _____

- I understand that failure to abide by the policies will be grounds for disciplinary action and possible dismissal from the program. _____

Student's Name: _____ **ID Number:** _____
(Print)

Student's Signature: _____ **Date:** _____

**HUMAN SUBJECTS DOCUMENT
ASSUMPTION OF RISK AND CONSENT TO PROCEDURES**

General Information

During this course you will be participating in laboratory activities in which learning by students requires the use of human subjects as part of the training. As a part of these learning activities you will be asked to perform specific skills as well as be the subject of specific skills practiced by students. These learning activities will be conducted under the supervision of the course instructor.

Benefits

The activities listed have been selected because they are skills essential to the learning process and the faculty believe that realistic practice is essential for optimum learning.

Bloodborne Pathogen Exposure

It is important that you be aware that blood and other body fluids have been implicated in the transmission of certain pathogens, particularly Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV), the virus responsible for Acquired Immune Deficiency Syndrome (AIDS). In order to minimize risk of exposure to bloodborne pathogens, the student must agree to follow Standard Precautions guidelines as well as comply with regulations outlined in the OSHA Bloodborne Pathogen Standard.

Risks/Discomforts

Participation may create some anxiety or embarrassment for you. Some procedures may create minor physical or psychological discomfort. Specific risks are listed below.

Your Rights

You have the right to withhold consent and to withdraw consent after it has been given. You may ask questions and expect explanation of any point that is unclear.

Learning Activity	Specific Benefit	Risks/Discomfort
Venipuncture using both evacuated tube system (ETS) and syringe system	Student gains experience needed prior to performing procedures on actual patients	Possibility of hematoma or bruising; slight, temporary pain with procedure; slight risk of temporary nerve inflammation
Skin puncture of the finger tip	Same as above	Slight, temporary pain upon puncture; minimal possibility of infection (provided area is kept clean)
Optional Learning Activity	Specific Benefit	Risks/Discomfort
Skin puncture of the forearm for Bleeding Time Test (BTT)	Same as other activities listed above	Same skin puncture activity listed above; plus possibility of a small scar at incision site

I have read the above Human Subjects Document. I acknowledge my understanding of the risks and benefits described. My questions have been answered. I agree to participate as a subject in the learning activities listed above.

Signature of student

Date