University of Arkansas – Fort Smith
College of Health Sciences
Health Care Provider Statement/Medical Release

Prior to entrance into a health sciences program, a medical release must be completed by your health care provider. Note: If at any time during the program your health status changes, you must have your health care provider complete a new medical release form. This form, with the student's and health care provider's signature, is required prior to return to clinical following absence due to health problems or changes in health status. The faculty reserves the right to request the student to submit a new health care provider statement/medical release in the event the student demonstrates evidence of clinical performance affected by physical, emotional, or mental limitations.

All College of Health Sciences (CHS) students must be physically, emotionally, and academically able to safely demonstrate completion of all required learning activities. Learning activities include successful completion of course, clinical, and theory objectives in order to successfully complete the CHS curriculum. All students must submit the health care provider statement/medical release that includes a medical history questionnaire and a physical ability requirements. CHS students will be treated respectfully regardless of race, color, national origin, gender, age, religion, or disability. In turn, CHS students will treat their clients respectfully regardless of race, color, national origin, gender, age, religion, or disability. University of Arkansas – Fort Smith (UAFS) provides reasonable accommodation and services to otherwise qualified students who have physical, emotional, and/or learning disabilities unless making the accommodation poses an undue hardship on the University or jeopardizes client safety.

CHS students will be in clinical courses requiring the safe application of both gross and fine motor skills as well as critical thinking skills. All of these skills are an inherent element of clinical practice. Usual and required activities routinely conducted by students include care for clients that may be ambulatory or comatose and involves all age ranges from premature infants to gerontology clients. Required abilities are: walking, standing for up to twelve hours, bending, reaching, turning, listening, observation, and moderate to heavy lifting (at least 75 pounds). There always exists potential exposure to communicable diseases and other pathogens.

STUDENT AFFIRMATION: I understand the student academic role and clinical performance requirements as noted on the physical abilities requirement form and agree that I have the primary responsibility of my own health status. I agree that I will not knowingly place myself, clients, or others in unsafe situations based upon my physical, mental, or emotional limitations. I have completed and signed the physical abilities requirements form and medical questionnaire. I authorize my health care provider to release the information requested below concerning my health status to the CHS. A student not being truthful or falsifying the health policy documents will be dismissed from the CHS Program.

Printed name of student:

Signature of student: Date:

HEALTH CARE PROVIDER Instructions: Please answer the following questions with the understanding of the academic role and clinical performance requirements of CHS students. Please do not attach any medical records.

1. Does the student have any medications, limitations, or disabilities identified on the medical history questionnaire (see page 2) or physical ability requirement list (see page 3) that would interfere with the performance of the academic or clinical requirements specified above on this form? If yes, specify.
   ☐ Yes ☐ No
2. Based upon review of pages 2 and 3, what special accommodations are medically necessary to assist the student with academic and clinical performance? Please mark N/A if not applicable.
3. State any instructions or limitations with which the student has been advised to comply. Please mark N/A if not applicable.

Physician/Clinic Stamp or Seal

Signature of Health Care Provider (credentials) Date

Print Name of Health Care Provider Office Address (include city, state, zip)

Note: The signatures of both the student and health care provider are required for admission. The names and information must be legible to be accepted. Illegible documents will be returned to the student.

University of Arkansas – Fort Smith
College of Health Sciences
Medical History Questionnaire

Name:_____ Date:_____
Last First Middle

Home Address:_____ Phone:_____

Gender:_____ Date of Birth:_____

A. Check either yes or no-give details of a "yes" answer in section B that follows.

Have you ever been treated for conditions or had indications of:

	Yes	No		Yes	No
1. Eye/vision problems			2. Skin rashes or eczema		
3. High blood pressure			4. Fainting or dizziness		
5. Tuberculosis or lung disease			6. Head Injury		
7. Asthma			8. Convulsions/Seizures		
9. Diabetes			10. Varicose veins		
11. Emphysema			12. Kidney/Bladder problems		
13. Epilepsy or seizure disorder			14. Allergies		
15. Arthritis/Rheumatism/Bursitis			16. Hemorrhoids		
17. Disease or pain of bones/joints			18. Hepatitis		
19. Ear problems			20. Psychiatric problems		
21. Muscle spasms			22. History of substance abuse		
23. Reaction to medications			24. Anemia/Blood disorders		
25. Reaction to chemicals			26. Heart problems		
27. Neck, shoulder, or back problems			28. Pregnancy		

B. List below full details to questions answered "YES" in Section A, above. Use a separate sheet of paper if needed. A medical release for any of the above will be required for admission.

Question #	Condition/Treatment/Management	Date

C. Do you take medicine regularly? ☐ Yes ☐ No
If yes, list all prescribed and over-the-counter or herbal medications and reason for taking (use a separate sheet if needed):

Medication	Dosage	Reason
Ex. Tylenol	*325 mg every 4-6 hrs. as needed*	*headache*

I understand that being untruthful or withholding information on the medical release questionnaire will result in dismissal from the CHS Program.

Student Signature_____ Date_____

I have reviewed the medical history questionnaire and attest that this student does not take any medications or have any medical limitations prohibiting safe clinical performance.

_____ _____
Signature of Health Care Provider (credentials) Date

University of Arkansas – Fort Smith
College of Health Sciences
Physical Abilities Requirements

Student Name: _____

Semester of Program Admission: _____

R-Regularly O-Occasionally			
Abilities	R	O	**Measurable Descriptor**
Vision: Corrected or Normal	X		Ability to read syringes, labels, instructions, & equipment
Color Vision	X		Color coded equipment
Hearing	X		Ability to hear through some equipment & noisy environments
Touch Temperature Discrimination	X		Palpation pulses & discriminate temperature & sensation; Use equipment requiring fine motor skills
Smell	X		Differentiate body odors, drainage, skin, & stool odor
Finger Dexterity/	X		Manipulation of equipment, dressings, IV & other functions requiring finger dexterity; assessment
Intelligible oral communication	X		Communication with clients, staff members, peers & faculty
Appropriate non-verbal communication	X		Therapeutic communication with client and health care team
Pushing	X		Lbs/ft: 100, equipment, carts with and without clients
Pulling	X		Lbs/ft: 50, equipment, & client carts
Lifting	X		Lbs/ft: 50, clients, equipment, and supplies
Floor to waist	X		Lbs 75: 3 man lift of patients
Reaching forward	X		Moving clients & equipment
Carrying	X		Lbs 50
Standing & Walking	X		Long periods, up to twelve hours
Sitting	X		Infrequent and short periods, break and lunch
Stooping/Bending	X		Infrequent and short periods; adjusting equipment
Kneeling/Crouching		X	Infrequent and short periods; adjusting equipment
Running		X	Infrequent, emergency situations
Crawling		X	Short periods, emergency, adjusting equipment
Climbing	X		Infrequent, patient care activities
Stairs (ascending/descending)		X	Infrequent, emergency situations
Turning (head/neck/waist)	X		Frequent extended periods; may position for long periods
Repetitive arm movement	X		Key Boards/Computer

I have read, understand, and accept the above working conditions expected of a CHS student in the academic and clinical setting and certify that I am able to meet these requirements.

Student Signature_____ Date_____

I have reviewed the physical abilities requirements for a CHS student in the academic and clinical setting and certify that this student is able to meet these requirements.

_____ _____
Signature of Health Care Provider (credentials) Date

University of Arkansas – Fort Smith
College of Health Sciences
Immunizations/Certification Requirements

My signature indicates that I understand the College of Health Sciences has immunizations/certification requirements and that I am in compliance with requirements. I understand copies of these proofs of immunizations/certification will be presented to the clinical agencies. Failure to initiate and maintain a current health record will prevent attending the clinical experience resulting in failure of the course and/or dismissal from the program.

Student Signature_____ Date_____

University of Arkansas – Fort Smith
College of Health Sciences
Health Care Provider Statement/Medical Release

Office Use Only	
Stamp Date Received:	
Approval for class/clinical ☐ Yes ☐ No	Program Director Signature:

Hepatitis B Vaccine Waiver

Vaccine-preventable disease levels are at or near record lows. Even though most infants and toddlers have received all recommended vaccines by age two, many under-immunized children remain, leaving the potential for outbreaks of disease. Many adolescents and adults are under-immunized as well, missing opportunities to protect themselves against diseases such as Hepatitis B, influenza, pneumococcal disease, and Varicella Zoster.

The University of Arkansas - Fort Smith College of Health Sciences encourages students/faculty to follow the recommendations of the Center for Disease Control and Prevention (CDC). The CDC strongly recommends that health care workers (HCW) (e.g., physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, hospital volunteers, and administrative staff) receive vaccination for vaccine-preventable diseases.

I understand and have read the information regarding Hepatitis B on the CDC website www.cdc.gov. I understand the significance of the Hepatitis B vaccination requirement for HCW. I choose NOT to obtain the Hepatitis B vaccinations. Based on this, **I HEREBY WAIVE ANY CLAIMS AGAINST UA FORT SMITH, ITS BOARD OF TRUSTEES, OFFICERS, AND AFFILIATING AGENTS FROM ANY AND ALL LIABILITY, RESPONSIBILITY, DAMAGE, OR LOSS, WHETHER KNOWN OR UNKNOWN EXISTING OR POTENTIAL, AS A RESULT OF ANY CONTACT OR CONSEQUENCE THAT MAY ARISE FROM MY EXPOSURE.**

_____ _____

Signature Date

Influenza Vaccine Waiver

Vaccine-preventable disease levels are at or near record lows. Even though most infants and toddlers have received all recommended vaccines by age two, many under-immunized children remain, leaving the potential for outbreaks of disease. Many adolescents and adults are under-immunized as well, missing opportunities to protect themselves against diseases such as Hepatitis B, influenza, pneumococcal disease, and Varicella Zoster.

The University of Arkansas - Fort Smith College of Health Sciences encourages students/faculty to follow the recommendations of the Center for Disease Control and Prevention (CDC). The CDC strongly recommends that health care workers (HCW) (e.g., physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, hospital volunteers, and administrative staff) receive vaccination for vaccine-preventable diseases.

I understand and have read the information regarding Influenza on the CDC website www.cdc.gov. I understand the significance of the Influenza vaccination requirement for HCW. I choose NOT to obtain the Influenza vaccinations. Based on this, **I HEREBY WAIVE ANY CLAIMS AGAINST UAFS, ITS BOARD OF TRUSTEES, OFFICERS, AND AFFILIATING AGENTS FROM ANY AND ALL LIABILITY, RESPONSIBILITY, DAMAGE, OR LOSS, WHETHER KNOWN OR UNKNOWN EXISTING OR POTENTIAL, AS A RESULT OF ANY CONTACT OR CONSEQUENCE THAT MAY ARISE FROM MY EXPOSURE.**

SIGNING THIS WAIVER DOES NOT RELEASE ME FROM THE REQUIREMENTS OF THE CLINICAL FACILITY RELATED TO THE INFLUENZA VACCINE.

Signing this waiver does not release me from clinical facility requirements related to the influenza vaccine.

_____ _____

Signature Date