UAFS
COLLEGE OF HEALTH, EDUCATION, AND HUMAN SCIENCES

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STUDENT 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: 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 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? Mark N/A if not applicable.

3. State any instructions or limitations with which the student has been advised to comply. Mark N/A if not applicable.

SIGNATURE OF HEALTH CARE PROVIDER (CREDENTIALS) _____ **DATE** _____

PHYSICIAN/CLINIC (STAMP OR SIGNATURE OR BUSINESS CARD)

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.

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MEDICAL HISTORY QUESTIONNAIRE

TYPE OF COMPLETION: SELECT ALL THAT APPLY

☐ ABSENCE ☐ CHANGE OF MEDICATION ☐ CHANGE IN MEDICAL STATUS

LAST NAME	**FIRST NAME**	**MIDDLE NAME**	**TODAY'S DATE**	
HOME ADDRESS		**CITY**	**STATE**	**ZIP**
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			15.	Arthritis/Rheumatism/Bursitis		
2.	Skin rashes or eczema			16.	Hemorrhoids		
3.	High blood pressure			17.	Disease or pain of bones/joints		
4.	Fainting or dizziness			18.	Hepatitis		
5.	Tuberculosis or lung disease			19.	Ear problems		
6.	Head injury			20.	Psychiatric problems		
7.	Asthma			21.	Muscle spasms		
8.	Convulsions/Seizures			22.	History of substance abuse		
9.	Diabetes			23.	Reaction to medications		
10.	Varicose veins			24.	Anemia/Blood disorders		
11.	Emphysema			25.	Reaction to chemicals		
12.	Kidney/Bladder problems			26.	Heart problems		
13.	Epilepsy or seizure disorder			27.	Neck, shoulder, or back problems		
14.	Allergies			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 reasons for taking (use a separate sheet if needed):

Medication	Dosage	Reason
Ex. Tylenol	*325 mg every 4-6 hours 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

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PHYSICAL ABILITIES REQUIREMENTS

STUDENT NAME	**SEMESTER OF PROGRAM ADMISSION**

R – Regularly **O** - Occasionally	**R**	**O**	
ABILITIES	X		**MEASURABLE DESCRIPTOR**
Vision: Corrected or Normal	X		Ability to read syringes, labels, instructions and equipment
Color Vision	X		Color coded equipment
Hearing	X		Ability to hear through some equipment and noisy environments
Touch Temperature Discrimination	X		Palpation pulses and discriminate temperature and sensation; Use equipment requiring fine motor skills
Smell	X		Differentiate body odors, drainage, skin, and stool odor
Finger Dexterity	X		Manipulation of equipment, dressings, IV and other functions requiring finger dexterity; assessment
Intelligible Oral Communication	X		Communication with clients, staff members, peers and faculty
Appropriate Non-Verbal Communication	X		Therapeutic communication with client and health care team
Pushing	X		Pounds/Foot: 100, equipment, carts with and without clients
Pulling	X		Pounds/Foot: 50, equipment and client carts
Lifting	X		Pounds/Foot: 50, clients, equipment and supplies
Lifting Floor to Waist	X		Pounds 75: 3 man lift of patients
Reaching Forward	X		Moving clients and equipment
Carrying	X		Pounds 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 listed above for a CHS student in the academic and clinical setting and certify that this student is able to meet these requirements. If restrictions are needed, they are noted above.

Signature of Health Care Provider (credentials)	Date

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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

OFFICE USE ONLY			
STAMP DATE RECEIVED:			
PROGRAM DIRECTOR OR DESIGNEE SIGNATURE:			
APPROVED FOR CLASS/CLINICAL:	□ YES □ NO	DATE:	