HEARTSAVER

Heartsaver® First Aid CPR AED

American Heart Association®

Sydney Elliott

has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Heartsaver® First Aid CPR AED Program.

Optional modules completed:

Exam, Child CPR AED, Infant CPR

Issue Date
1/23/2020

Recommended Renewal Date
01/2022

Training Center Name
Southern Regional AHEC CTC

Instructor Name
Gary Frazier

Instructor ID
01160409640

Training Center ID
NC04286

eCard Code
206001122860

Training Center Address
1601 Owen Dr
Fayetteville NC 28304-3425 USA

QR Code

Training Center Phone Number
(910) 678-7216

To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

Cherokee County Health Department

Flow Sheet Report: **TB Skin Test**

	PPD Given	PPD Read
DATE GIVEN	08/24/2020	
TIME GIVEN	1525	
REASON	SCHOOL	
MANUFACTURER/LOT#	SP C5714AA	
SITE	LFA	
WHEAL MEASURMENT	7MM	
PLACED BY	Misty Postell, RN	
Educated To RTC WITHIN 48-72H	yes	
DATE READ		08/26/2020
Time Read		1525
READ BY		Misty Postell, RN
INDURATION		0mm
POSITIVE OR NEGATIVE		NEGATIVE

PERSONAL HEALTH HISTORY-CONTINUED *(Please print in black ink) To be completed by student*

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin		X	
Sulfa		X	
Other antibiotics (name)		X	
Aspirin		X	
Codeine Other pain relievers		X	
Other drugs, medicines, chemicals (specify)		X	
Insect bites		X	
Food allergies (name)	✓		peanuts

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)		X	
Have you ever been a patient in any type of hospital? (Specify when, where, and why)		X	
Has your academic career been interrupted due to physical or emotional problems? (Please explain)		X	
Is there loss or seriously impaired function of any paired organs? (Please describe)		X	
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)		X	
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)		X	

IMPORTANT INFORMATION....PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):

I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

Sydney Elliott — **Signature of Student**

08/19/20 — **Date**

Signature of Parent/Guardian, if student under age 18

Date

REPORT OF MEDICAL HISTORY (Please print in black ink) To be completed by student

Elliott	Sydney	Faith	0229745	238-97-4540
LAST NAME (print)	FIRST NAME	MIDDLE/MAIDEN NAME	STUDENT ID#	SOCIAL SECURITY NUMBER

457 Graham Rd	Murphy	NC	28906	828-361-6406
MAILING ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

DATE OF BIRTH (mo/day/yr) 07/15/01 GENDER ☐ M ☑ F MARITAL STATUS S ☑ M ☐ OTHER ☐

PREVIOUSLY ENROLLED HERE YES ☐ NO ☑

IF YES, DATES _____

SEMESTER ENTERING (circle): ~~FALL~~ SPRING (SUMMER) YEAR 2020

United Healthcare P.O. Box 740800 Atlanta GA 1-800-782-3740
HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY) 30374080 AREA CODE/TELEPHONE NUMBER

Joel B. Elliott 244-47-5235 Elliott Bro. Mechanical
NAME OF POLICY HOLDER SOCIAL SECURITY NUMBER EMPLOYER

80760096 4 796179 IS THIS AN HMO/PPO/MANAGED CARE PLAN? ☐ YES ☒ NO
POLICY OR CERTIFICATE NUMBER GROUP NUMBER

Brannon Elliott DAD
NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

457 Graham Rd Murphy NC 28906 828-835-6266
ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY HEALTH HISTORY (Please print in black ink) To be completed by student

Has any person, related by blood, had any of the following:

	Yes	No	Relationship
High blood pressure		X	
Stroke		X	
Heart attack before age 55		X	
Blood or clotting disorder		X	

	Yes	No	Relationship
Cholesterol or blood fat disorder		X	
Diabetes	✓		
Glaucoma		X	

	Yes	No	Relationship
Cancer (type): Leukemia		✓	
Alcohol/drug problems		X	
Psychiatric illness		X	
Suicide		X	

PERSONAL HEALTH HISTORY (Please print in black ink) To be completed by student

HEIGHT 5'3" WEIGHT 115lb

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure		X	
Rheumatic fever		X	
Heart trouble		X	
Pain or pressure in chest		X	
Shortness of breath		X	
Asthma		X	
Pneumonia		X	
Chronic cough		X	
Head or neck radiation treatments		X	
Tumor or cancer (specify)		X	
Malaria		X	
Thyroid trouble		X	
Diabetes		X	
Serious skin disease		X	
Mononucleosis		X	

	Yes	No	Year
Hay fever		X	
Allergy injection therapy		X	
Arthritis		X	
Concussion		X	
Frequent or severe headache		X	
Dizziness or fainting spells		X	
Severe head injury		X	
Paralysis		X	
Disabling depression		X	
Excessive worry or anxiety		X	
Ulcer (duodenal or stomach)		X	
Intestinal trouble		X	
Pilonidal cyst		X	
Frequent vomiting		X	
Gall bladder trouble or gallstones		X	

	Yes	No	Year
Jaundice or hepatitis		X	
Rectal disease		X	
Severe or recurrent abdominal pain		X	
Hernia		X	
Easy fatigability		X	
Anemia or Sickle Cell Anemia		X	
Eye trouble besides need glasses		X	
Bone, joint, or other deformity		X	
Knee problems		X	
Recurrent back pain		X	
Neck injury		X	
Back injury		X	
Broken bone (specify)		X	
Kidney infection		X	
Bladder infection		X	

	Yes	No	Year
Kidney stones		X	
Protein or blood in urine		X	
Hearing loss		X	
Sinusitis		X	
Severe menstrual cramps		X	
Irregular periods		X	
Sexually transmitted		X	
Blood transfusion		X	
Alcohol use		X	
Drug use		X	
Anorexia/Bulimia		X	
Smoke 1+ pack cigarettes/week		X	
Regularly exercise	✓		2020
Wear seat belt	✓		2020
Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Southwestern
COMMUNITY COLLEGE

Health Sciences
Student Medical Form

Student Name: Sydney Faith Elliott

Student ID#: 0229745

Program of Study: Physical Therapist Assistant

Term of Enrollment: 2020/2021

Revised 1.29.16

Frequently Asked Questions

1. How/where can I obtain my childhood immunization record?

You may be able to obtain a copy of your childhood immunization record from one of the sources listed on page 6.

2. What if I do not have a primary physician to assist me in completing the required Immunization and Physical Examination forms? Are there other agencies that I can go to?

You may go to any physician's office, urgent care center or your local health department where the physician/physician assistant/nurse practitioner would be available to complete the required forms. We encourage you to shop around so that you may get the best prices for the physical examination and any of the required immunizations.

3. What is a titer? For which immunizations does SCC accept titers?

For immunization purposes, a titer refers to the measurement of antibodies found in a patient's blood, which tells if a patient has immunity to a certain disease. If a student knows that they have had a certain immunization but cannot provide documented proof, then they may have a blood titer drawn to prove immunity. Please note that in the event that the titer shows that the student is not immune, then they will be required to obtain the necessary immunization or sign the appropriate waiver, if applicable.

SCC will accept titers for the following immunizations: MMR, Hepatitis B, and Varicella. If a titer is drawn to document immunity, the student is required to submit a copy of the actual lab report showing the actual immunity values and not just stating "negative" or "positive".

Hepatitis B Vaccination Information

Any student who has not received the Hepatitis B vaccine and wishes to decline the Hepatitis B vaccine does not need a Hepatitis B titer. Students who decline the Hepatitis B vaccine will be at risk for developing the disease and must sign the *Hepatitis B Virus Vaccine Declination Statement* below. The student must consult with his or her healthcare provider before signing this statement.

Hepatitis B Virus Vaccine Declination Statement

I understand that due to my exposure to blood or other potentially infectious materials while enrolled as a Health Sciences student at Southwestern Community College, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have discussed my exposure risk with my healthcare provider and been given the opportunity to be vaccinated with Hepatitis B vaccine by my healthcare provider. However, I decline Hepatitis B vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Sydney Elliott
Student Signature

08/19/20
Date

IMMUNIZATION RECORD	(Please print in black ink) To be completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.			
				Student ID#
Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	Social Security #

SECTION A REQUIRED IMMUNIZATIONS	mo./day/year	mo./day/year	mo./day/year	mo./day/year
DTP or Td	(#1) 9-12-01	(#2) 11-16-01	(#3) 1-23-02	(#4) 8-31-06
Td booster	11-12-12			
Polio	9-12-01	11-16-01	1-23-02	8-31-06
MMR (after first birthday) series of two doses or immunity by positive blood titer	7-16-02	8-31-06		****Titer Date & Result
MR (after first birthday)				
Measles (after first birthday)			*(Disease Date NOT Accepted)	**Titer Date & Result
Mumps	7/16/02	8-31-06	*(Disease Date NOT Accepted)	**Titer Date & Result
Rubella			*(Disease Date NOT Accepted)	**Titer Date & Result

	mo./day/year	mo./day/year	mo./day/year	
Haemophilus influenzae type b	9-12-01	11-16-01	1-23-02	10-16-02
Hepatitis B series only	9-12-01	11-16-01	1-23-02	****Titer Date & Result
Hepatitis A/B combination series				
Varicella (chicken pox) series of two doses or immunity by positive blood titer	7-22-04	8-31-09		****Titer Date & Result
Tuberculin (PPD) Test (within 6-12 months) Date read / mm induration	Done elsewhere (IR)			
Chest x-ray, if positive PPD Date / Results				
Treatment, if applicable Date				

SECTION B RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain departments and/or clinical sites. Please consult your department for specific requirements.

Meningococcal	Received the meningococcal vaccine? No ☐ Yes ☑
If Yes, please indicate date(s) vaccine was received (mo./day/year)	11-12-12 and 8-1-17

	mo./day/year	mo./day/year	mo./day/year
Pneumococcal			
Hepatitis A series only			

Signature or Clinic Stamp REQUIRED:

[signature] PA-C — 8-31-2020

Signature of Physician/Physician Assistant/Nurse Practitioner — **Date**

Tiffany Rouse — 7067452229

Print Name of Physician/Physician Assistant/Nurse Practitioner — **Phone Number**

63 Pleasant Hill Rd — Blairsville — GA — 30512

Office Address — **City** — **State** — **Zip Code**

* Only laboratory proof of immunity to rubella, mumps or measles is acceptable if the vaccine is not taken. History of rubella, mumps or measles disease, even from a physician, is not acceptable.

** Attach Lab report

Do Not Write in This Space

PHYSICAL EXAMINATION *(Please print in black ink)* *To be completed and **signed** by physician or clinic*

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	Social Security Number
Elliott	Sydney		7-15-2001	

Mailing Address	City	State	Zip Code	Phone Number

Height 5'3" Weight 119 TPR 98° / 87 / 100°2 BP 101/65

Vision: Corrected Right 20/ 20 Left 20/ ____
Uncorrected Right 20/ 20 Left 20/ 20
Color Vision passed
Hearing: (gross) Right pass Left pass
15 ft. Right pass Left pass

Urinalysis: Sugar: (-) Albumin ____
Micro ____
Hgb or Hct (if indicated) ____
STS (may be required by some departments)
Date ____ Results ____
Recommendations ____

Are there abnormalities?	Normal	Abnormal	Description (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat	✓		
2. Eyes	✓		
3. Respiratory	✓		
4. Cardiovascular	✓		
5. Gastrointestinal	✓		
6. Hernia	✓		
7. Genitourinary	✓		
8. Musculoskeletal	✓		
9. Metabolic/Endocrine	✓		
10. Neuropsychiatric	✓		
11. Skin	✓		
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes ____ No ✓
Explain ____

B. Is student under treatment for any medical or emotional condition? Yes ____ No ✓
Explain ____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited ✓ Limited ____
Explain ____

D. Is student physically and emotionally healthy? Yes ✓ No ____
Explain ____

Based on my assessment of this student's physical and emotional health on 8-31-2020 (Date), he/she appears able to participate in the activities of a health profession in a clinical setting. Yes ✓ No ____ If no, please explain ____

[signature] PA-C 8-31-2020
Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

Tiffany Rouse 003539
Print Name of Physician/Physician Assistant/Nurse Practitioner **License Number**

63 Pleasant Hill Road Blairsville GA 30512 706 745 2229
Street Address **City** **State** **Zip Code** **Telephone Number**

High Mountain Healthcare, LLC

URINALYSIS

Ordered by: ___ Dr. Bradford ___ Tiffany Rouse ___ Steve Rouse

___ Susan Dressler ___ Andrea Fowler ___ Leslie Hughes

Date: Aug 31, 2020
Patient Name: Sydney Elliott , 07/15/2001
Patient Chart/ID #0000006536

Leukocytes Θ

Nitrite Θ

Urobilinogen Θ

Protein 30

PH 5.0

Blood Θ

Sp Gravity 1.020

Ketone small

Bilirubin Θ

Glucose Θ

Send for Culture? _____ Yes _____ No

DX: _____

___ R35.0 Urinary Freq

___ N39 UTI, Unspecified

___ R30.0 Dysuria

___ R31.9 Hematuria

___ R35.1 Nocturia

___ R50.9 Fever

___ R10.9 Abd pain, unspec.

P.O. Box 2239 Blairsville, GA 30514
63 Pleasant Hill Road Blairsville, GA 30512
706-745-2229 FAX: 706-745-0836

Hearing and Vision Screening

Today's Date:Aug 31, 2020

Patient:Sydney Elliott Date of Birth:07/15/2001

Y 20db HL Y 25db HL Y 40db HL

Frequency (Hz)	500	1000	2000	4000
Right Ear	Y	Y	Y	Y
Left Ear	Y	Y		

Y= Response N= No Response

Both Eyes (OU): 20/20

Right Eye (OD): 20/20

Left Eye (OS): 20/20

Comments:

Screeening by:_____