Nursing Program -- Student Health Form

Office use only: **CPR_____** **Picture_____**

Applicant for: ( ) Fall ( ) Spring ( ) Summer Semester Year:_____ Program:_____

DIRECTIONS: Please **print** in ink or **type** Section I before going to your physician for examination. Be sure to answer **ALL** questions fully. Information provided will not influence your admission status and will not be released to unauthorized persons without your written consent.

SECTION I **(To be completed by student)** Date:_____

Name: _____
(Last) (First) (Middle)

Home Address: _____
(Number and Street) (City) (State) (Zip)

_____ (_____) _____ -_____ (_____) _____-_____ _____/_____/_____
Student College ID Home Phone Number Cell or Business Number Birthday

IN CASE OF EMERGENCY NOTIFY

Name: _____ Relationship: _____

Address: _____
(Number and Street) (City) (State) (Zip Code)

Telephone: _____
(Home) (Business)

A: PAST MEDICAL HISTORY

Check **all** boxes below. On the next page give approximate dates and treatments on **ALL** positive answers.

HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO
Rubeola (Red Measles)			Diabetes		
Rubella (German Measles)			Kidney/Bladder Abnormality		
Mumps			Heart Disease/Heart Murmurs		
Chicken Pox			Arthritis		
Rheumatic Fever			Stomach/Intestinal Abnormality		
Infectious Mono			Hay Fever		
Hepatitis			Allergies		
Asthma			Color Blindness		
Positive T.B. Skin Test			Recurrent Headaches		
Mental/Emotional Disorders			Back Problems		
Frequent Dizziness			High Blood Pressure		
Epilepsy/Convulsions			Organ Transplants		
Other					

B: DIAGNOSIS

If you answered, **"YES"** to any question in Section I A, complete the following:

DATE	DIAGNOSIS (use list from previous page)	TREATMENT

C: SURGERIES

DATE	TYPE OF SURGERY

D: MEDICATIONS

MEDICATIONS
1)
2)
3)
4)

E: **RESTRICTIONS**

Has your physical activity been restricted or limited during the past three years? ( ) YES ( ) NO
(This includes your ability to lift) If yes, give reasons and duration.

_____

_____

IMPORTANT DEADLINE: Physical **must** be within six (6) months prior to the first day the student starts class.

NOTE: **Student** is responsible for completion of the Health Form. This includes signatures, all attachments, Physician/ Physician Assistant/Nurse Practitioner fills in all spaces on physical exam section, immunization page is complete and all blocks signed (office Nurse may sign immunization page).

SECTION II: PHYSICAL EXAMINATION **(To be completed by Physician, or Nurse Practitioner)**

Directions to the Physician/Nurse Practitioner: Please review the student's **Past Medical History** (see previous pages), complete the **Physical Examination** below, check all systems yes or no, and comment on all positive findings. The information you provide will **not** influence the student's admission status to the Nursing and Health Sciences program for which he/she has been accepted.

NAME _____
(Last) (First) (Middle)

Height _____ Weight _____ Blood Pressure _____

Corrected Vision **(Must be checked)** Right 20/_____ Left 20/_____

Hearing **(Must be checked)** Right ( ) Normal ( ) Impaired
Left ( ) Normal ( ) Impaired

Does the student have any **abnormalities** in the following systems? (Give dates, description for abnormality and treatment on all **positive** findings. See Below) Check **all** systems "YES" or "NO".

A: SYSTEMS

SYSTEM	YES	NO
Eyes		
Ears		
Nose, Throat		
Neurological		
Respiratory		
Cardiovascular (to include heart murmurs)		
Gastrointestinal		
Musculoskeletal		
Metabolic/Endocrine		
Genitourinary		
Skin		
Immunological		
Psychiatric		

B: DIAGNOSIS If you answered, "YES" to any item above, complete the following.

DATE	DIAGNOSIS (use list above)	TREATMENT

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

_____ _____

Student's Signature **Date**

I certify that there are no physical or emotional factors that would preclude/limit this student from participating in classroom and clinical education.

(If not, please explain) _____

_____

_____

_____

_____

_____ _____

Physician's/Physician Assistant's/Nurse Practitioner's Name (print) **Telephone Number**

_____ _____

Physician's/Physician Assistant's/Nurse Practitioner's Signature **Date**

Please Note: Physical exam **must** be within **six (6) months** prior to the first day of class.

Nursing Students will be **notified by letter** with the date their Health Forms are due. Health Forms **must** be hand delivered to Jerry Kennedy R.N., Health Science Building, Room 152, Airport Campus.

Phone Number (803) 822-3465
E-Mail: kennedyj@midlandstech.edu

Revised Spring 2013

MANDATORY IMMUNIZATIONS/TESTS • Midlands Technical College, Nursing Program

STUDENT NAME: _____ Student ID # _____

This form must be filled out completely and each block signed by a Health Care Professional (Signature with Credentials).
The following immunizations or titers indicating immunity are **required** before entering the Nursing Program. Each immunization or titer **must** have specific date and state immunity **(Pos. /Neg.).**

VACCINE	DATE OF IMMUNIZATION OR TITER State immunity (Pos. or Neg.)	HEALTH CARE PROFESSIONAL **Signature with Credentials**
T-Dap Injection (Booster required every 10 years)	Date of vaccine: _____	Sign:_____
MMR – 2 Vaccines or Positive Titers Dose #1 – on or after 1st.Birthday Dose #2 – 4 weeks after dose #1 or later If either titer is negative – MMR required MMR titers are **required** if you cannot show Proof of 2 MMRs and cannot have the Vaccine. Date of Vaccine ➔	Mumps Titer Date: _____ **Pos. Neg.** Rubeola Titer Date:_____ **Pos. Neg.** Rubella Titer Date_____ **Pos. Neg.** #1_____ #2_____	Sign:_____ Sign:_____ Sign:_____ Sign:_____
Varicella (Chicken Pox) **Titer Required** If titer is negative – you will need to have 2 Vaccines – 4 weeks apart Date of Vaccines➔	Titer Date:_____ **Pos. Neg.** #1_____ #2_____	Sign:_____ Sign:_____
***2 Step PPD** Skin Test **(Mantoux Only)** Step 1➔ If Step 1 is negative – 1-3 weeks after Step 1 Give Step 2 **(see below)** Step 2➔ ****Positive** TB Skin Test (See Below) ****BCG** (See Below)	Date Given_____ Date Read_____ Result_____ Date Given_____ Date Read _____ Result_____	Sign:_____ Sign:_____
*****Hepatitis B Series - Titer required after series (see below)** If titer is negative – you will need to repeat the series and 6 weeks after the 3rd. vaccine have a titer drawn. Date of Vaccines➔	Titer Date: _____ **Pos. Neg.** #1_____ #2_____ #3_____	Sign: _____ Sign: _____ Sign: _____ Sign: _____

All students entering Health Sciences and Nursing Programs at Midlands Technical College must provide proof of all vaccines listed above. You may be exempt from the MMR only if: (1) You are pregnant or trying to conceive. (2) You have a history of anaphylactic reaction to gelatin, neomycin, or eggs. If you cannot receive the MMR/Varicella vaccine you will be **required** to attach a Physician's statement to your Health Form, and have titers for each done. **Students** born before 1957 are assumed to be protected through natural disease. Varicella titer required for all students.

*Two-step testing is used to distinguish boosted reactions and reactions due to new infection. If the reaction to the first test is negative, a second test should be done 1 to 3 weeks later. Two-step testing should be used for the initial skin testing of adults who will be retested periodically, such as health care workers. If you have had a PPD within the year it may be used as the first step. *Core Curriculum On Tuberculosis, What the Clinician Should Know,* CDC, Third Edition, 1994, page 22, 23.

If TB Skin Test is **Positive a copy of a Chest X-Ray report, within the last year, is required and **must** be attached to your Health Form.

Students that have had the BCG vaccination $\geq$ 10 years ago **must have the PPD skin test; however, those who have received BCG within the last 10 years should be individually assessed for the need for testing. *Infection Control and OSHA Essentials;* Health Studies Institute, page 30. A Physician's statement **must** be attached to your Health Form regarding his/her assessment.

***Hepatitis B vaccine is mandatory for students entering Health Sciences and Nursing Technologies, **except** Health Information Management Technology. Students who cannot take the vaccine will be **required** to present a physician's statement. A **Hepatitis B Titer** is required for **all** Nursing students; six weeks after completion of the Hepatitis B Series a titer **must** be drawn to check for immunity. If series was done in the past a titer is required.

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