444 Western Boulevard
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Phone (910) 455-1221

Nursing and Allied Health Programs

Student Medical Form

Student Name: _____

Program: _____

Date: _____

Instructions for Completion of the Student Medical Form

The information provided in this health form by the student and the health care provider is confidential and protected by the Health Insurance Portability and Accountability Act Privacy Rule.

Student Must Complete:

1. The student must complete and sign the Personal and Family History prior to the physical exam.
2. The student should complete the immunization requirements and must provide the school with documentation of any immunizations, titers, or screening tests done prior to the current physical exam. Students who are providing titers showing immunity in lieu of a vaccination record must submit the laboratory result documenting the titer.

Provider Must Complete:

3. If new immunizations, blood tests, or screening tests are done during the physical exam visit, the health care provider must document, initial those, and sign the immunization summary.
4. The health care provider must complete and sign the physical exam form.

Additional Requirements for Surgical Tech, Medical Lab Technician, and Dental

- Dental and Surgical tech students require a vision exam including a fundoscopic exam
- Medical lab technician students require a color vision test

Instructions regarding immunizations and health screening tests

In order to protect both you and your patients, our clinical agencies require the following immunizations and health screening tests. In order to attend clinical rotations, you must provide all of the required information unless you have a documented medical contraindication.

Use the following checklist to confirm that you have provided all required information regarding immunizations and health screening tests.

_____ **Measles, mumps, rubella (MMR)**

Unless you were born before 1957, you must provide the following:

- Two MMR vaccinations after your first birthday
  OR
- Titers showing immunity to each of the three disorders

_____ **Varicella**

- Two varicella vaccines
  OR
- Titer showing immunity (Surg Tech will need a Positive titer for clinical requirements).

_____**Tetanus/diphtheria (TD) or adult tetanus/diphtheria/pertussis (Tdap)**

- Td booster every 10 years AND
- One-time dose of Tdap as soon as possible if individual has not received Tdap previously (regardless of when previous dose of Td was received).

_____ **Tuberculosis screening**

- Baseline individual TB Risk Assessment including TB symptoms evaluation AND
- Initial TB/PPD: Two step PPD within 12 months of program start (both tests must be administered and read within 21 days) **OR** a Quantiferon Gold **OR** T-spot blood within 12 months of program start
- Students with a positive TB skin test in the past, due to either TB exposure/infection or BCG vaccination, a chest x-ray within the last 2 years is required along with the Baseline Individual TB Risk Assessment and TB symptom evaluation. (Note: If a PPD is positive, chest x-ray should be negative for TB disease and individual asymptomatic for TB).
- Annual Tuberculosis Risk Assessment and Attestation

_____ **Hepatitis B**

- Energix-B or Recombivax HB three doses series or; HepA-HepB three dose series; if incomplete series then Heplisav-B (2 doses, 4 weeks apart)
  OR
- A titer showing immunity (quantitative results required)
- Since the series and titers take an extended period of time, you may be mid-process when clinicals begin. Provide all documentation that you have. Your Department Head will give you interim instructions.

Influenza

- Influenza immunization is not part of your fall admission requirements, but you will be required to receive the vaccine annually during the flu season unless you have a documented medical contraindication or religious objection. Declination of influenza may result in inability to participate and complete clinical requirements. You will be informed of the appropriate time to receive this vaccination.

COVID-19

- The COVID-19 vaccination is required by clinical sites for participation in clinicals. The following meet requirements:
  - 2 doses of Moderna COVID-19
  - 2 doses of Pfizer Covid-19
  - 1 dose of Janssen Covid-19
  - 2 doses of Novavax Covid-19
  - 1 dose of Moderna or Pfizer Covid-10 Bivalent
  - Communicate with your Department Head regarding religious or medical exemption at least 30 days prior to beginning program

Personal and Family Health History

Name _____

The following two pages are be completed by student prior to the physical exam.

Last name _____ **First name**_____ **Middle initial**_____

Date of Birth _____ **Social Security # (last 4 digits)** _____

Gender _____

Address _____

Preferred Phone _____

Emergency Contact and Phone_____

……..

Are you allergic to any medications? If so, what medications, and what was your reaction? _____

_____

_____

Check any illness or medical conditions that you have had:

___ high blood pressure
___ rheumatic fever
___ heart disease
___ asthma
___ other lung disorder
___cancer
___ malaria
___ thyroid disorder
___ diabetes
___ allergies
___ arthritis
___ frequent headaches
___ severe head injury
___ autoimmune disorder
___ disabling depression
___ anxiety
___ gastrointestinal disorder
___ hepatitis
___ hernia
___ fatigue
___ anemia
___ vision or eye disorder
___ recurrent back pain
___ neck or back injury
___ kidney infection
___ hearing loss
___ sexually transmitted infection
___ blood transfusion

Provide details about any items checked. Attach an additional sheet if necessary.

_____

_____

_____

Do you smoke? ____ How many cigarettes/day? ____ Drink alcohol? _____ How many drinks/wk? ____

List all medications you take regularly. _____

_____

_____

_____

Has any person related to you by blood had any illness or condition below? If so, check the condition and state the relationship of the family member to you.

___ high blood pressure _____
___ stroke _____
___ heart disease _____
___ blood disorder _____
___ high cholesterol _____
___ diabetes _____
___ glaucoma _____
___ cancer _____
___ substance abuse _____
___ psychiatric illness _____

Do you have any conditions that limit your physical activity?

Have you ever been hospitalized? Specify when and why.

Have you received treatment for a psychiatric, emotional, or behavioral disorder?

Do you have any vision problems not corrected with glasses or contact lenses or any hearing impairment?

Have you seen a physician in the past six months for anything other than routine well visits?

Have you had any serious injuries or illnesses not already noted?

Statement: I have personally supplied the above information and attest that it is accurate and true to the best of my knowledge.

Signature of student _____ Date _____

Printed name of student _____

Immunization Record

Name _____

The student should complete the Immunization Record prior to the exam and provide documentation of any prior immunizations, titers, or screening tests to support the previous immunizations.

If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

Required immunizations

	Date	Date	Date	Date
DTP or Td (Initial series)	___/___/___	___/___/___	___/___/___	___/___/___
Td or Tdap (within past 10 years)	___/___/___			
Tdap	___/___/___			
MMR (2 after 1st birthday) **or titer**	___/___/___	___/___/___		
Varicella (2) **or titer**	___/___/___	___/___/___		
Hepatitis B (initial series) **or titer**	___/___/___	___/___/___	___/___/___	
Hepatitis B (optional 2 to complete series)	___/___/___	___/___/___		
COVID-19 date & type	___/___/___	___/___/___	___/___/___	___/___/__

Titers (where indicated)

	Date	Result
Rubeola (measles)	___/___/___	
Mumps	___/___/___	
Rubella	___/___/___	
Varicella	___/___/___	
Hepatitis B titer #1* (after original series)	___/___/___	**mIU/mL***
Hepatits B titer # 2 * (after single booster)	___/___/___	**mIU/mL***
	___/___/___	

***A quantitative hepatitis B titer result is required.**

Tuberculosis screening (most recent) ***Either PPD or TB blood testing is acceptable for health occupation students.***

	Date Placed	Date Read	Interpretation
PPD Step 1	___/___/___	___/___/___	
PPD Step 2	___/___/___	___/___/___	
QuantiFERON Gold or T-Spot (pos, neg, or indeterminate)	___/___/___		

OR

Screening following positive PPD history (most recent)

	Date	Result
Chest X-ray (pos or neg)	___/___/___	
Record of TB screening (attach form and indicate low risk or high risk)	___/___/___	

If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

_____ _____

Signature of physician, nurse practitioner, or physician's assistant **Date**

_____

Print Name of Health Care Provider

Physical Examination

Name _____

Height _____ **Weight** _____ **TPR** _____/_____/_____ **BP** _____/_____

	Normal	Abnormal	Description or Comments
Head, ears, nose, throat			
Eyes			
Respiratory system			
Cardiovascular system			
Gastrointestinal system			
Abdomen			
Genitourinary system			
Musculoskeletal system			
Endocrine system			
Neurological system			
Skin			
Mental health status			

Is the student under treatment for any medical condition? If yes, provide brief details of disorder and treatment.

Are there currently any limits on the student's physical activity? How long will these limits apply?

Examiner's Statement: **Based on my assessment of this student's physical and emotional health, at this time they appear to be able to participate in the activities of a health profession in a clinical setting.** _____ **Yes** _____ **No**
Comments:

_____ _____

Signature of physician, nurse practitioner, or physician's assistant **Date**

_____ _____

Print Name of Health Care Provider **Area Code and Phone**

_____

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