



NURSING AND HEALTH OCCUPATIONAL PROGRAMS

TO BE COMPLETED BY THE STUDENT:

Disclosure and Release of Health History and Immunization Requirements

Student's Name: _____ Birth date: _____
Last First Middle Month/Day/Year

Address: _____
Street City, State Zip Code

Telephone: (____) _____ *SWC e-mail address (primary): _____

* **all program communications will be via SWC e-mail**

Secondary e-mail address: _____

DISCLOSURE AND CERTIFICATION STATEMENTS

I hereby grant permission for the release and/or disclosure of health history and health screening medical information between and among authorized college, clinical facilities, and hospital personnel.

CONSENT FOR RELEASE OF HEALTH REPORT, RECORDS AND/OR MEDICAL INFORMATION

I realize the various health agencies where Health Profession students gain experience may wish for students to be certified in good health. I hereby consent to the communication of my health record from Southwestern College to participating agencies as requested.

Furthermore, I acknowledge it is my responsibility to keep current at all times and provide the following to SWC Nursing & Health Occupation Programs Office: a copy of my immunization records, annual physical exam dated within one year, proof of TB clearance dated within one year (unless positive; chest X-Ray report is good for five years), titers (if applicable), seasonal flu shot, CPR certification and/or other medical requirements. Note: the only CPR card accepted is AHA Healthcare Provider or Basic Life Support [BLS] Provider.

Once admitted into the Nursing or Health Occupation Program, I will be required to submit a copy of all current records to the Nursing Office. Students in the ADN, LVN to ADN Step Up, IDC Step Up, VN or Surgical Tech Program must upload records to the Complio online immunization tracking system. The online immunization tracking system does not apply to CNA, Acute Care CNA, Central Service Technology or Operating Room Nurse Programs.

Student Signature

Date

SWC ID#



SOUTHWESTERN COLLEGE

NURSING AND HEALTH OCCUPATIONAL PROGRAMS**HEALTH HISTORY FORM**

Health History – TO BE COMPLETED BY THE STUDENT	CHECK “YES” or “NO”	
1. Have you ever been hospitalized? If yes, provide information below.	Yes	No
a. List health problem:	Date:	
b. List operation(s) performed:	Date(s):	
2. Are you under a physician's care now? If yes, provide information below.	Yes	No
a. List name of physician:		
b. List name of health problems:		
c. Are you taking medications on a regular or frequent basis?	Yes	No
If yes, list meds (attach sheet, if needed):		
3. Do you have any allergies?	Yes	No
a. List medications you are allergic to:		
b. List other allergies: (food, pollen, contact, animal, dust):		
4. Have you had a back, neck or wrist injury?	Yes	No
a. Was medical attention or surgery required?	Yes	No
Please explain:		
5. Have you had an injury to any muscle, bone, ligament or tendon?	Yes	No
a. Was medical attention or surgery required?	Yes	No
Please explain:		
6. Do you smoke? If yes, packs per day = []	Yes	No
<i>For questions 7-9 below: if you answer “yes,” please explain your limitation(s) on a separate sheet of paper.</i>		
7. Do you have any limitation(s) which may affect your ability to lift, turn, or transfer patients or otherwise restrict you from participating fully in the RN training program?	Yes	No
8. Do you have any limitation(s) in the use of your senses, such as sight or hearing, which would limit your ability to practice a health profession?	Yes	No
9. Do you have any condition which might interfere with your ability to practice a health profession safely? If yes, please explain your limitation(s) in detail on a separate sheet of paper.	Yes	No
PLEASE INDICATE WITH A CHECK IF YOU OR A FAMILY MEMBER HAVE HAD:	SELF	FAMILY MEMBER
a. Hypertension (High blood pressure)		
b. Heart disease		
c. Diabetes		
d. Cancer		
e. Tuberculosis		
f. Seizure disorder		
g. Asthma		
h. Chickenpox		
i. Drug and/or alcohol abuse		

Student Signature_____
Date_____
SWC ID#



SOUTHWESTERN COLLEGE

NURSING AND HEALTH OCCUPATIONAL PROGRAMS

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER: Southwestern College requires a physical examination for students enrolling in Nursing and Health Occupation Programs. A statement of your knowledge of this student's health (mental and physical) will be greatly appreciated. This report goes directly to the Nursing Education Department and will be released only to authorized college, clinical facilities and hospital personnel.

STUDENT'S NAME _____
 (PRINT CLEARLY) Last First Middle

BP _____ P _____ R _____ Ht. _____ Wt. _____

Normal Abnormal

Vision: _____ R.Eye 20/ L.Eye 20/
 Glasses ☐ Yes ☐ No C/Lens ☐ Yes ☐ No

Hearing: _____

If **Abnormal**, please complete the following decibel information.

500 hz R. Ear _____ dcb L. Ear _____ dcb
 1000hz _____ dcb _____ dcb
 2000hz _____ dcb _____ dcb

PHYSICAL EXAM:

	Normal	Abnormal	Description:
1. General Appearance	_____	_____	_____
2. Skin	_____	_____	_____
3. Nodes	_____	_____	_____
4. Skull	_____	_____	_____
5. Ears	_____	_____	_____
6. Eyes	_____	_____	_____
7. Nose	_____	_____	_____
8. Oropharynx	_____	_____	_____
9. Dental	_____	_____	_____
10. Neck & Thyroid	_____	_____	_____
11. Chest	_____	_____	_____
12. Cardiovascular	_____	_____	_____
13. Abdomen	_____	_____	_____
14. Hernia Check	_____	_____	_____
15. Musculoskeletal	_____	_____	_____
a. Neck	_____	_____	_____
b. Back	_____	_____	_____
c. Shoulders	_____	_____	_____
d. Knee	_____	_____	_____
e. Ankle	_____	_____	_____
f. Feet	_____	_____	_____
g. Other	_____	_____	_____
Neurological	_____	_____	_____

Comments: _____



NURSING AND HEALTH OCCUPATIONAL PROGRAMS

Supplemental Medical Guidelines

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER:

Nursing students must be able to do total patient care in all nursing areas without physical, emotional, cognitive or psychological limitations. Female students must be able to provide care to male patients and male students must be able to provide care to female patients. Written documentation of complete recovery from any previous injury and/or illness must be provided. Following is a brief description of some of the types of activities that students will perform while working with patients in the hospital. Students are expected to meet all of these parameters.

Note: Any issues regarding disabilities (temporary or permanent) will be reviewed per ADA Act 1990 and reasonable accommodations will be considered per regulation.

1. Moderate to heavy lifting and carrying (20-40 pounds).
 2. Pushing, pulling, bending, and kneeling around patients using various types of hospital equipment such as wheelchairs, gurneys, lifting devices and specialized beds; work in small confined spaces, move around rapidly.
 3. Fine motor dexterity using both hands while preparing medications and manipulating a variety of instruments and assessment devices.
 4. Rapid mental processing and simultaneous motor coordination; necessary to manipulate syringes, start IV's; assist with patient ADL's; write/type; perform procedures.
 5. Extensive periods of walking and standing (4 or more hours at one time).
 6. Visual discrimination including depth perception and color vision; vision sufficient to make physical assessments of patients and equipment; perform procedures.
 7. Ability to hear the spoken word in settings where other sounds are present. Able to hear clearly on the telephone, hear through a stethoscope (sound enhanced OK), to hear cries for help, to hear alarms on equipment and emergency signals and various overhead pages.
 8. Working with hands in water (frequent hand washing is required); ability to palpate superficially and deeply; discriminate tactile sensations.
 9. Working with various materials and substances to which some individuals may be allergic (such as latex).
 10. Ability to speak clearly in order to communicate with patients, families, staff, physicians; need to be understood on the telephone.
 11. Have sufficient emotional stability to perform under stress (both academically and in clinical setting).
 12. Ability to communicate effectively in English both verbally and in the written format for the classroom setting and the clinical setting.
- Note: Casts, splints, braces are not allowed in the clinical setting.*

Mark the appropriate box below:

☐ After reviewing the "Supplemental Medical Guidelines" listed above and based on findings from the patient's history and physical exam, I certify that the above student is physically and mentally capable of fully participating in Southwestern College Nursing and Health Occupational Programs.

☐ The following health problem(s) should be further evaluated **PRIOR** to participation in a clinical assignment:

Examiner's Signature & Title

Physical Exam Date

License # (required)

Business Card or facility stamp must
accompany this form.

The statement below is to be reviewed and signed by the student:

I understand these physical and other requirements for the Nursing Program as specified above. I will inform my healthcare provider, faculty, and the Program Director of any/ all disability issues immediately as they occur, and upon acceptance into the program. *If applicable*, I will make an appointment with Disability Services with any concerns or disability issues.

Student Signature: _____ Date: _____ SWC ID#: _____



IMMUNIZATION REQUIREMENTS

Southwestern College Health Services Nurse (main CV campus). A copy of immunization records, and/or titers (lab results) must be included with this form for any vaccine or titer given.


NAME: _____ STUDENT ID#: _____
Last First Middle

MMR (Measles, Mumps, Rubella) vaccine		Date #1:	Signature:
		_____	_____
OR		Date #2:	Signature:
		_____	_____
Titers		Titer Date:	Signature:
Measles	<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune	_____	_____
Mumps	<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune	Titer Date: _____	Signature: _____
Rubella	<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune	Titer Date: _____	Signature: _____

Hepatitis B vaccine		Date #1:	Signature:
		_____	_____
OR		Date #2:	Signature:
		_____	_____
		Date #3:	Signature:
		_____	_____
Titer	<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune	Titer Date:	Signature:
		_____	_____

Varicella/IgG vaccine (Chickenpox)	Date #1:	Signature:
OR	Date #2:	Signature:
Titer <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune	Titer Date:	Signature:

Tetanus/Diphtheria and Acellular Pertussis vaccine (TDAP) <i>Must be within 10 years</i>	Date #1:	Signature:
	_____	_____

Influenza/Flu vaccine <i>(current seasonal shot using Consortium form attached-pg 7)</i>	Date #1: _____	Signature: _____	
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MANTOUX TUBERCULIN SKIN TEST REQUIREMENTS

Last

First

Middle

TB test is positive, a chest x-ray is required. Chest x-ray results must be dated within five years.

measured in mm.

Practitioner, Registered Nurse, Vocational Nurse or Southwestern College Health Services Nurse.

STEP #1 - First PPD Test

Date: _____

Manufacturer: Dose: 0.1mL

Dose: 0.1mL

Time Given: _____

Exp. Date: Lot#:

Lot#:

Given By:

Date: _____

Results: _____ mm

Time Read:

Read By:

STEP #2 - Second PPD Test (7-21 days after Step #1)

Date:

Manufacturer: Dose: 0.1mL

Dose: 0.1mL

Time Given:

Given By _____

Date:

Results: mm

Time Read: _____

Read By:

OR

Chest X-Ray (Only if Mantoux positive, Chest X-Ray required)

Chest X-Ray Date:

☐ Negative☐ Positive

Signature:

(must be dated within five years)

(A copy of the chest X-Ray report must be submitted with this form)

OR

Quantiferon TB

Date:

☐ Negative☐ Positive

Signature:

(A copy of the lab report must be submitted with this form)

