MEDICAL EXAMINATION FORM

TO THE PHYSICIAN: Southwestern College requires a physical examination for students enrolling in the Nursing and Health Occupations 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) *Last* *First* *Middle Initial*

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

_____ _____
Applicant's Signature Date

Health History – to be completed by student.	**CHECK "YES" or "NO"**	
1. Have you ever been hospitalized?	Yes	No
a. List health problem:	Date:	
b. List operations performed:	Date(s):	
2. Are you under a physician's care now?	Yes	No
a. List name of personal M.D.:		
b. List health problems:		
c. Are you taking medications on a regular basis?	Yes	No
List:		
3. Do you have any allergies?	Yes	No
List medications you are allergic to:		
List other allergies: (food, pollen, contact, animal, dust):		
4. a. Have you had a back or neck or wrist injury?	Yes	No
b. Have you had an injury to any muscle, bone, ligament or tendon?	Yes	No
c. Was medical attention or surgery required?	Yes	No
Please explain:		
5. Do you smoke? Packs per day =	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		

To be completed by the PHYSICIAN:

STUDENT'S NAME_____
(PRINT) *Last* *First* *Middle Initial*

BP_____ P_____ R_____ Ht._____ Wt._____

	Normal	**Abnormal**			
Vision:	_____	_____	R.Eye 20/	L.Eye 20/	
			Glasses ☐ Yes ☐ No		C/Lens ☐ Yes ☐ No
Hearing:	_____	_____			
				R. Ear	L. Ear
If Abnormal, please complete the following decibel information.			500 hz	_____dcb	_____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: _____
_____

Southwestern College Nursing & Health Occupations Programs
Supplemental Medical Guidelines

TO BE COMPLETED BY THE PHYSICIAN:

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 this 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.

I understand these physical and other requirements for the nursing program. I will inform faculty and the Program Director of any/all disability issues immediately as they occur (and upon acceptance into the program).

I will make an appointment with Disability Services with any concerns or disability issues.

Student Signature: _____ Date: _____

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 the Southwestern College's Nursing and Health Occupations Programs.

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

_____

_____

_____
Examiner's Signature

_____
Date
License #_____

Business Card or facility stamp must accompany this form.

SOUTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATIONS PROGRAMS

Immunization Record and Statement of Health

Date: _____

Name: _____Birthday: _____
Last First Middle Month/Day/Year

Address:_____
Street City, State Zip Code

Telephone: (_____) _____ E-mail address _____

CONSENT FOR RELEASE OF HEALTH REPORT

I realize that the various health agencies where Health Professions' students gain experience may wish these students to be certified in good health. I hereby consent to the communication of my health record from Southwestern College to those cooperating agencies as they may request.

SIGNATURE ***x***_____ DATE: _____
(Applicant)

HEALTH QUESTIONNAIRE (To be completed by applicant. Please respond to each question).

1. Do you have any physical limitations which would affect your ability to lift, turn or transfer patients? Or otherwise restrict you from participating fully in the RN training program?

Yes _____ No_____ (check one only)

2. Do you have any limitation in use of your senses, such as in sight or hearing, which would limit your ability to practice a health profession?

Yes _____ No _____ (check one only)

3. Do you have any other condition which might interfere with your ability to practice a health profession safely?

Yes _____ No _____ (check one only)

If you have answered yes to any of the above, please explain your limitations in detail on a separate sheet of paper.

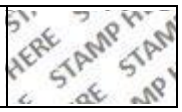
List any medications you have been taking on a regular or frequent basis during the past year.

SOUTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATIONS PROGRAMS
IMMUNIZATION REQUIREMENTS

To be cleared by the Southwestern College Nursing and Health Occupations Programs Department, supporting documentation must accompany this form for any vaccine or titer given at another facility. This form will only be accepted with a signature and stamp from the following: Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, or Southwestern College Health Services Nurse.

NAME: _____
Last *First*

STUDENT ID#: _____ ☐ Staff ☐ Student ☐ Other _____

MMR (Measles, Mumps, Rubella)	Date #1:	Signature:	
	Date #2:	Signature:	
OR **Seropositivity (Blood Test)**	S. Date:	Signature:	
If born *before* January 1, 1957 only 1 dose of MMR or seropositivity is required. **If born *after* January 1, 1957 two doses of vaccine are required or seropositivity.**			
Hepatitis B	Date #1:	Signature:	
	Date #2:	Signature:	
	Date #3:	Signature:	
OR **Seropositivity (req'd)** **(Blood Test)**	S. Date:	Signature:	
Tetanus/ Diptheria and Acellular Pertussis (TDAP) *Must be given 2009 or after.*	Date #1:	Signature:	
Varicella (Chickenpox)	Date #1:	Signature:	
	Date #2:	Signature:	
OR **Seropositivity (Blood Test)**	S. Date:	Signature:	
Influenza/Flu Vaccine	Date #1:	Signature:	

SOUTHWESTERN COLLEGE NURSING AND HEALTH OCCUPATIONS PROGRAMS
MANTOUX TUBERCULIN SKIN TEST REQUIREMENTS

NAME: _____

Last *First*

ID#: _____ ☐ Staff ☐ Student ☐ Other _____

All Health Profession students are required to have a 2-step INTRADERMAL TST (MANTOUX) prior to program start, unless previously positive. A TB test or Questionnaire is due yearly for all students and must be cleared through Health Services prior to submitting to program office.

To be cleared by the Southwestern College Nursing & Health Occupations Programs, supporting TB documentation must accompany this form for any TB test completed at another facility. **The size of indurations must be measured in mm.** On this form, a signature and stamp will only be accepted from the following: Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, or Southwestern College Health Services Nurse).

Step #1 (First PPD Test)		
Date: _____ Time Given: _____	Manufacturer: _____ Dose: 0.1mL Exp. Date: _____ Lot#: _____ Given By:	
Date: _____ Time Read: _____	Results: _____mm Read By:	
If Mantoux Positive: Chest X-Ray Required Date: _____	Results: ☐ Negative ☐ Positive (a copy of the report must be submitted with this form to the Program office)	
Or Seropositivity **Quantiferon TB**	Date: _____ ☐ Negative ☐ Positive	

Step #2 (7-21 days after Step #1- Second PPD Test)		
Date: _____ Time Given: _____	Manufacturer: _____ Dose: 0.1mL Exp. Date: _____ Lot#: _____ Given By:	
Date: _____ Time Read: _____	Results: _____mm Read By:	
If Mantoux Positive: Chest X-Ray Required Date: _____	Results: ☐ Negative ☐ Positive (a copy of the report must be submitted with this form to the Program office)	