



Students are required to undergo a physical examination performed by a certified physician. The physical exam includes the following tests:

- GHP – includes CBC with diff
- Physical Examination
- Mumps, Rubella & Rubeola Titer (MMR)
You are considered IMMUNE to measles, mumps and rubella if you can provide a certificate of immunity, signed by a healthcare professional of either:
 - Two doses of MMR (measles-mumps-rubella) vaccine, given one year or more from the date of birth, and given at least 28 days or more from each other. The certification must include the year, month, and day that the immunizations were administered, or
 - A laboratory record of serologic immunity (antibody titers).
- Varicella Titer
- Diphtheria and Tetanus immunization record
 - If you are an international student, then you are considered IMMUNE to tetanus and diphtheria if you can provide a certificate of immunity signed by a healthcare professional showing at least three vaccinations against tetanus and diphtheria, and if one of those shots was given within the past 10 years.
 - If you are a domestic student, then you are considered IMMUNE if you can provide a certificate of immunity signed by a healthcare professional showing that your last vaccination against tetanus and diphtheria were given within 10 years of the term of enrollment.
 - **Serologic tests (antibody titers) are not acceptable evidence of immunity against either tetanus or diphtheria**
- Mantoux Skin Test or Chest X-ray
- Urinalysis
- 8 Panel Drug Screen

All immunization records must include the year, month and day that the immunizations were administered and the record must be on official letterhead OR signed by a healthcare professional.

Note:

- All pages of the physical exam forms must be completely filled and signed by the attending physician where applicable. **All laboratory results must be attached.**
- The student must sign or initial applicable sections.
- The completed physical exam forms, together with the laboratory results, must be submitted to the college by the student.

MEDICAL / PHYSICAL EXAM AND PHYSICIAN'S REPORT

- i) All sections of the form must be completed and signed.
- ii) Physical exam results must be valid & within six months from date of admission into the program.

Date Test was performed. _____

A) Student Medical Information:

First Name	Middle Name	Last Name	
Street	City	State	Zip

B) Medical History

Attending Physician, please indicate the status of all listed health checks below.

Note: The student's medical history is used by the college for informational purposes only in case the student has any medical condition that may require special consideration.

Test	Result	Test	Result	Test	Result
Height		Weight:		Blood Pressure	
Pulse		Heart		Neurological	
Skin		Abdomen		Genito-urinary	
ENT		Hernia		Thorax	
Mouth		Breast		Lungs	
Teeth		Back		Pulse:	
Vision	R: L:	Corrected	R: L:		
Hearing	R: L:	Corrected	R: L:		

- Extremities:

- Pelvic (optional). Date and result:

Physician's Comments (if any):

 Physician's Name

 Signature

Tests/ Immunization Record

Copies of completed test results must be attached.

A) TB SKIN TEST

(2-Step Mantoux) required unless a previous positive test.

(i) Mantoux # 1

Date Given	Date Read	Result	Signature	_____
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(ii) Mantoux # 2

Date Given	Date Read	Result	Signature	_____
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B) CHEST X-RAY: (Required for positive TB skin test only).

Result: _____

C) IMMUNIZATION RECORD

- | | Had Disease? | Date Immunized |
|----------------------------------|--------------|---|
| • Diphtheria and Tetanus | Y_____N_____ | _____ |
| • Hepatitis B Vaccine (Optional) | Y_____N_____ | _____ |
| • Mumps Titer: | | _____ |
| • Rubeola Titer: | | _____ |
| • Rubella Titer: | | _____ |
| • Varicella Titer: | | _____.If result is negative, 2 injections required. |

Note: If titers are negative or equivocal, student must receive immunization.

Report immunization status. _____

- Summary of CBC: _____
- Complete urinalysis: _____
- Other diagnostic tests (Optional): _____

Physician's Initial

Summary of Physical Examination

Is student subject to health emergencies (e.g. epilepsy, fainting, heart problems, asthma, etc)?

Yes _____ No _____ If Yes, State Type: _____

Emergency procedure to be followed:

D) Does student have any type of infectious disease?

Yes _____ No _____ If Yes, State Type: _____

If student is currently receiving any medication or treatment, please indicate:

E) Does student have any allergies?

Yes _____ No _____ If Yes, State Type: _____

F) Is student's activity limited due to a history of a muscular skeletal problem/weight limitation?

Yes _____ No _____ If Yes, State Type: _____

G) Please indicate any medical or mental conditions which would limit this individual's participation in the Practical Nursing Program

H) Follow-Up:

Indicate any medical or mental conditions which you believe should have medical follow-up but will not limit this individual's participation in the Practical Nursing Program.

I have discussed with the student the requirement of Felbry College School of Nursing for Hepatitis B vaccine and recommend the following action:

Note: Felbry College School of Nursing does not require the Hepatitis B vaccine; however, it recommends the Hepatitis B vaccine for health care professionals. Please discuss with your physician and obtain his/her advice on whether you will need to start this series.

STATEMENT OF HEALTH

Student Name (Print) _____

Initial the appropriate response:

- a) _____ I affirm that that I am in good health and have no physical or mental limitations that will inhibit or prevent me from performing all appropriate procedures and services in relation to my role as a student nurse.
- b) _____ I do have a chronic illness, physical disability and/or mental limitation to my health (which may include alcohol or drug use) but I believe this does not significantly impair my ability to render quality patient care.

If you answer (b) above, a full statement of explanation must be attached. The statement must include the name and address of your personal physician.)

Student Signature: _____ Date: _____

Note: Student's statement of health and fitness to perform in the assigned role as a student nurse must be confirmed by the student's physician.

Summary of Physical Examination

Name of Physician (Print or Type): _____

Signature of Physician: _____

Examination Date: _____

Name of Hospital/Clinic: _____

Street City State Zip

Telephone: _____ Fax: _____