Felbry College - School of Nursing

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Health Requirements Form

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

- Physical Examination
- Bloodwork to include a CBC with diff
- 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. The certification must include the year, month, and day that the immunizations were administered, or ***a laboratory record of serologic immunity (antibody titers).***
- Tetanus Diphtheria (TDAP) vaccine
  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. ***Serologic tests (antibody titers) are not acceptable evidence of immunity against either tetanus or diphtheria.***
- Varicella Titer
- Annual Influenza Vaccine
- Mantoux Skin Test or Chest X-ray
- Urinalysis
- 10 Panel Drug Screen

Note:

- All pages of the physical exam forms must be filled in its entirely and signed by the Healthcare Provider.
- The student must sign or initial applicable sections.
- The completed physical exam form, to include **laboratory results**, must be submitted to the college by the student.
- 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 Provider.

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

(i) Mantoux # 1

Date Given	Date Read	Result	Signature
_____	_____	_____	_____

(ii) Mantoux # 2

Date Given	Date Read	Result	Signature
_____	_____	_____	_____

B) CHEST X-RAY (Required for positive TB skin test only).

Result: _____

C) IMMUNIZATION RECORD (attach results):

	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._____

- o Summary of CBC: _____
- o Complete urinalysis: _____
- o 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:_____