NAME: _____

SEM/YEAR: _____

EMAIL: _____

Student Medical Form for North Carolina Community College System Institutions

ROANOKE-CHOWAN COMMUNITY COLLEGE

Associate Degree Nursing Program

Revised: 2015, 2019

APPLICANT MEDICAL FORM CHECKLIST **{CLINICAL REQUIREMENTS}**
Acceptable completed forms MUST be in the student file.

1. Report of Medical History and Family Health History {pages 3 and 4} MUST be completed by the applicant and signed.

2. Physical Examination {page 6} must be completed. Statement of applicant's physical and mental/emotional health must be completed, dated, and signed by physician, PA, FNP, or have an agency stamp

IMPORTANT – The immunization requirements must be met. Acceptable Records of Your Immunizations May Be Obtained from Any of the Following {Be certain that your name, date of birth, and ID Number appear on the document. The records must be in black ink and the dates of vaccine administration must include, day, and year**. Keep a copy of your records**.}

- High School Records – These may contain some, but not all of your immunization information
- Personal Shot Records – must be verified by a doctor's stamp or signature or by a clinic or health department stamp
- Local Health Department
- Military Records
- Previous College or University – Your records do not transfer automatically. You must request a copy
- Health Care Facilities where you may be employed

Current Tetanus Booster and Tdap	1 dose Tdap, then Td Booster every 10 years
Hepatitis B or Hepatitis A/B Combination	2 or 3 doses depending on vaccine
MMR (Measles, Mumps, Rubella)	2 doses or positive titers (results include ref range)
Varicella	2 doses or positive titers (results include ref range)
Influenza	1 dose annually (before OCT 15)
PPD	Two step (two tests within the same 1-3 week period)

Applicants should adhere to vaccine schedule for initial vaccines and updates as required by clinical agencies.

Students will not be allowed to attend clinical until immunizations are complete.

Initialing this page indicates you have read and understand the clinical requirements.

_____

REPORT OF MEDICAL HISTORY *(Please print in black ink)* *Completed by applicant*

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN NAME PERSONAL ID# (PID) *SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo./day/yr.) _____ GENDER MALE FEMALE MARITAL STATUS ☐ SINGLE ☐ MARRIED

CLASS YOU ARE ENTERING (circle):

PREVIOUSLY ENROLLED HERE ☐ YES ☐ NO
IF YES, DATES _____

SEMESTER ENTERING (circle): FALL SPRING

HOSPITAL/HEALTH ISURANCE (NAME AND ADDRESS OF COMPANY) AREA CODE/TELEPHONE NUMBER

NAME OF POLICY HOLDER *SOCIAL SECURITY NUMBER EMPLOYER

POLICY OR CERTIFICATE NUMBER GROUP NUMBER IS THIS AN HMO/PPO/MANAGED CARE PLAN? ☐ YES ☐ NO

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY & PERSONAL HEALTH HISTORY *(Please print in black ink)* *Completed by applicant*

Has any person, related by blood, had any of the following?

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
Suicide			

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
High blood pressure				Hay fever				Jaundice or hepatitis				Kidney stones			
Rheumatic fever				Allergy injection therapy				Rectal disease				Protein or blood urine			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Hearing loss			
Pain or pressure in chest				Concussion				Hernia				Sinusitis			
Shortness of breath				Frequent or severe headache				Easy fatigability				Severe menstrual cramps			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Irregular periods			
Pneumonia				Severe head injury				Eye trouble besides need glasses				Sexually transmitted disease			
Chronic cough				Paralysis				Bone, joint, or other deformity				Blood transfusion			
Head or neck radiation treatments				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				Drug use			
Malaria				Ulcer (duodenal or stomach)				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Smoke 1+ pack cigarettes/week			
Diabetes				Pilonidal cyst				Broken bone (specify)				Regularly exercise			
Serious skin disease				Frequent vomiting				Kidney infection				Wear seat belt			
Mononucleosis				Gall bladder trouble gallstones				Bladder infection				Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name	Use	Dosage	Name	Use	Dosage

*Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION….PLEASE READ AND COMPLETE

STATEMENT BY APPLICANT (OR PARENT /GUARDIAN, IF APPLICANT UNDER AGE 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. **(Not applicable to community colleges.)**

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. **(Not applicable to community colleges.)**

_____ _____

Signature of Student **Date**

_____ _____

Signature of Parent/Guardian, if student under age 18 **Date**

Eastern CCEP Credentialing Checklist

The elements as specified on the *Eastern CCEP Clinical Passport* document serve as the minimum requirements for student participation in the clinical setting of the participating agencies. The list represents the highest standards as evaluated by the Eastern CCEP Committee. Note that clinical agency contracts may specify additional requirements based on the areas in which students may be placed or regulations established by that agency or health system.

Official documentation of all requirements must be kept by the school program or by the vendor contracted for electronic documentation.

Adopted 03/17; Rev. 10/25/17, 1/22/19

Incomplete health forms and immunization records will be subject to immediate disqualification from the admissions process.

IMMUNIZATION RECORD	**(Please print in black ink) Completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.**			
Last Name First Name Middle Name			Date of Birth (mo/day/year)	*Social Security #
SECTION A REQUIRED IMMUNIZATIONS				
	(mo/day/year)	(mo/day/year)	(mo/day/year)	(mo/day/year)
	(#1)	(#2)	(#3)	
Tdap (Tetanus-Diphtheria-Pertussis) T-dap – one dose				
Td (Tetanus) Booster – Clinical agencies require one vaccine every ten years				
MMR (after first birthday)				***Titer Date & Result (attach lab result)
MR (after first birthday)				***Titer Date & Result (attach lab result)
Measles** (after first birthday) (Clinical agencies require proof of vaccine or titer only)				***Titer Date & Result (attach lab result)
Mumps** (Clinical agencies require proof of vaccine or titer only)				***Titer Date & Result (attach lab result)
Rubella** (Clinical agencies require proof of vaccine or titer only)				***Titer Date & Result (attach lab result)
Hepatitis B series only OR **Hepatitis A/B** combination series				***Titer Date & Result (attach lab result)
Varicella (chicken pox) series of two doses or immunity by positive blood titer (Clinical agencies require proof of vaccine or titer only)				***Titer Date & Result (attach lab result)
Influenza (Clinical agencies require proof of vaccine)				
Tuberculin (PPD) Test (2 step within 1-3 week period) Date Read mm induration				
Chest x-ray, if positive PPD results Date Treatment if applicable Date				
SECTION B RECOMMENDED IMMUNIZATIONS			The following immunizations are recommended for all students.	
Meningococcal	Received the meningococcal vaccine. No ☐ Yes ☐			
If Yes, please indicate date(s) vaccine was received. (mo/day/year)				
SECTION C OPTIONAL IMMUNIZATIONS	mo/day/year		mo/day/year	mo/day/year
• Pneumococcal				
• Hepatitis A series only				

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****** Must repeat measles vaccine if received even one day prior to 12 months of age

******* Only laboratory proof if immunity to measles, mumps, rubella, and varicella is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

Immunization Signature Page

Signature or Clinic Stamp REQUIRED:

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

_____

Office Address

_____ _____ _____

City **State** **Zip Code**

The Health form, ADN Application, current NA 1, and current CPR should be included in the application packet. Health forms must be received by R-CCC Admissions on or before the March 1st deadline via postal mail. Health forms will not be considered if they are delivered in person, faxed, or email.

********NO WRITING BEYOND THIS POINT. FOR OFFICE USE ONLY. *******

Immunizations reviewed _____

Reviewer's Signature _____

COMMENTS:

PHYSICAL EXAMINATION *(Please print in black ink) Completed and **signed** by provider*

A physical examination is required by **some schools and/or programs** (consult your college or department for specific requirements). **If required**, it must be completed in black ink and signed by a licensed provider.

Last Name First Name Middle Name	Date of Birth (mo/day/year)	*Social Security Number

Permanent Address City State Zip Code	Area Code/Phone Number

Height _____ Weight_____ TPR _____/_____/_____ BP _____/_____

Vision: Corrected Right 20/ _____ Left 20/ _____

Uncorrected Right 20/ _____ Left 20/ _____

Color Vision _____

Hearing: (gross) Right _____ Left _____

15 ft. Right _____ Left _____

Urinalysis: Sugar:_____ Albumin _____

Micro _____

Hgb or Hct (if indicated) _____

STS (may be required by some departments)

Date _____ Results _____

Recommendations _____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
Explain _____

D. Is student physically and emotionally healthy? Yes _____ No _____
Explain _____

***** MUST BE COMPLETED BY HEALTH CARE PROVIDER*****

Based on my assessment of this student's physical and emotional health on _____ (Date), he/she appears able to participate in the activities of a health profession in a clinical setting. Yes_____ No_____ if no, please explain _____
_____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

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

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