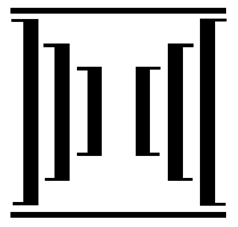
NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEM/YEAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Student Medical Form**

**for**

**North Carolina Community**

**College**

**System Institutions**



**Associate Degree Nursing**

**Program**

***Revised: 2015, 2019, 2021***

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

|  |  |
| --- | --- |
| COVID-19 Vaccination | Must indicate one dose or two doses as well as the manufacturer |
| Current Tetanus Booster and Tdap | 1 dose Tdap, then Td Booster every 10 years {must indicate if Booster} |
| 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 M ALE FEMALE MARITAL STATUS SINGLE MARRIED

SEMESTER ENTERING (circle): FALL

SPRING

CLASS YOU ARE ENTERING (circle):

FR. SO. JR. SR. GRAD. PROF.







PREVIOUSLY ENROLLED HERE YES NO

IF YES, DATES

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF POLICY HOLDER \*SOCIAL SECURITY NUMBER EMPLOYER

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IS THIS AN HMO/PPO/MANAGED CARE PLAN? YES NO

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 |
| Cancer (type): |  |  |  |
| Alcohol/drug problems |  |  |  |
| Psychiatric illness |  |  |  |
| Suicide |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | 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 |  |  |  |
|  |  |  |  |

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):**

1. 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.
2. 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.)**
3. 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, 1/27/2021

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

**Medical issues that will hinder vaccinations requires a doctor’s note (must be on letterhead) indicating issue and results if received/receiving vaccination.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***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): one dose  **Td (Tetanus) Booster**-Clinical agencies require one vaccine every ten years |  | | |  |  |  |
|  | | |  |  |  |
| **COVID-19 Vaccination: Indicate whether it is one dose or two doses** |  | | |  |  |  |
| **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 to 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 | | |  | |  |  |

|  |  |
| --- | --- |
| **\*** | 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 |
| **\*\*** | 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 , he/she appears able to  (Date)  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**

\*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.