BROWARD COLLEGE NURSING PROGRAM
ADMISSION MEDICAL HISTORY & PHYSICAL EXAMINATION

In order to participate in the clinical portion of any health science program, the student must complete a Medical History and Physical Examination Form. Admission into the Nursing Program is provisionally based upon acceptance of the approved health evaluation record.

Failure to submit the original form - complete with documentation - may prevent the student from progressing to the clinical portion of the program. Valid verification of immunizations is required for eligibility to attend clinicals at the health care agencies.

Students are responsible for the cost of the physical examination and any related expenses.

Section 1: Student Self-Report of Medical History
This section about past and current health status should be completed by the student **prior** to having the physical examination.

Section 2: Medical History and Physical Examination
The Health Care Examiner will review any documentation the student provides.

Immunization Verification

I. A PPD and/or CXR required annually, within the past 12 months. The PPD result must be documented in millimeters of induration. If a PPD is positive, a chest x ray is required every year. QuantiFERON TB Gold Test is not accepted.

II. A Tdap (Tetanus, Diphtheria, and Pertussis) vaccine is required within 10 years of the date of the examination.

III. A seasonal flu vaccine is required with documentation during flu season.

IV. Measles, Mumps, Rubella, Varicella, titers must be completed to verify immunity. Titers must be completed within 10 years of the date of the examination. All negative results necessitate a vaccination. If the Measles, Mumps, Rubella or Varicella titer is negative, two post-titer MMR or Varicella boosters are required. *A student stating that they have had the disease is NOT acceptable documentation*

V. Hepatitis B titer must be completed within the past ten years. If negative, the Hepatitis series must be completed (0, 1 month, 2 months after the second dose – 6 months after if using the combined Hepatitis A & B vaccine) OR the student can decline.

VI. Results of all laboratory blood tests and diagnostics are required.

VII. Examiner must initial after completing each section.

Health Care Examiner's Statement

This section is to be completed by a Licensed Professional Health Care Examiner (MD, DO, ARNP or PA **only**). All sections must be completed with a signature provided.

The following sections must be reviewed and signed by the student:

Section 3: Release of Information
Section 4: Verification of Compliance with Technical Performance Standards
Section 5: Permission to Render Medical Treatment

Submit the completed form – pages 2 through 5 – with all required documentation to the nursing office.

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Section 1: Student Self Report of Medical History – Please Print

Last Name	**First Name**	**Student ID**	
Address	**City**	**State**	**Zip**
Home Phone	**Work Phone**	**Cell**	
Emergency Contact Name	**Relationship**	**Contact at:**	
BC Email Address			

Review of Systems / Medical History — please check all that apply			
Abnormal Bleeding		Hernia	
Allergies		High Blood Pressure	
Anemia		High Cholesterol	
Anxiety		Intestinal / Stomach	
Arthritis		Low Back Condition / Scoliosis	
Asthma		Mental Disorder	
Cancer		Mononucleosis	
Chest Pain		Neck Condition	
Chronic Cough		Neurological Disorder	
Concussion / Head Injury		Orthopedic Disorder	
Depression		Prior Surgery	
Diabetes		Rheumatic Fever	
Ear Problem / Hard of Hearing		Seizure Disorder	
Eating Disorder		Sickle Cell Trait	
Eye Problem / Vision Loss		Sinus Problems	
Fracture of		Skin Disease	
Gallbladder Disease		Spleenectomy	
Headaches / Migraines		Sprain of	
Heart Murmur or Arrhythmia		Syncope / Fainting	
Heart Problem (other)		Thyroid Disease	
Hepatitis		Tuberculosis	

Provide information regarding any of the boxes checked above. Explain medical/psychological occurrence and current status.

_____

_____

_____

Please indicate any health concerns, if any, that you presently have:

_____

_____

_____

Allergies: ____None _____Latex ____Penicillin/Ampicillin ____Other

Section 2: Medical History & Physical Examination

Examiner: Please examine this student as you would for a routine check-up. This student will be working closely with clients in various health care settings. Please indicate/comment on any abnormal findings; using additional sheets if necessary or providing further documentation.

HEIGHT: _____WEIGHT: _____BLOOD PRESSURE: _____

SYSTEM	NORMAL	FINDING	COMMENTS/PREVIOUS CONDITIONS/SURGERY
Cardiovascular			
Endocrine/Metabolic			
Eyes/Ears/Nose /Throat			
Gastrointestinal			
Genitourinary			
Integumentary			
Musculoskeletal			
Neurological			
Respiratory			

Examiner: Summarize diagnosis, treatment and prognosis or provide any official documentation as it relates to any written response.

_____

_____

Is the student currently taking any medications? **YES** **NO**
If yes, please list:

Is the student restricted from participating in unlimited physical activities in the clinical area? If yes, please specify limitation: **YES** **NO**

Does the student require any follow-up health supervision? **YES** **NO**
If yes, please specify:

Within the last 5 years, has the student been treated for substance related (drug/alcohol) disorder? **YES** **NO**
If yes, please specify:

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NAME:		
Mantoux PPD – Tuberculin Test and/or CXR required annually – within past 12 months		
PPD Test Date	Attach supporting documentation	
Date & Time Administered	Administered by	
Manufacture of PPD	Expiration Date	Lot Number
Date Read	Read By	
Results in Millimeters of Induration		
If results are positive or restricted from a PPD due to the BCG vaccine, a chest X-ray is required		
Chest X-ray Date	Attach Results of Chest X-ray	Examiner's Initials
Tdap (Tetanus, Diphtheria, Pertussis) – within 10 years		
Date Vaccination Provided	Attach supporting documentation	Examiner's Initials
Flu Vaccine - seasonally between September 15 & March 31		
Date of Vaccine	Injection Site	Attach supporting documentation
Lot Number	Expiration	Examiner's Initials
MMR - Rubeola(Measles), Mumps(Parotitis), Rubella(German Measles) within 10 years		
Date Titer Completed	Attach supporting documentation	Examiner's Initials and date
#1 Date Booster completed for Negative Titer		Examiner's Initials and date
#2 Date Booster completed for Negative Titer		Examiner's Initials and date
Varicella – Chickenpox – within 10 years		
Date Titer Completed	Attach supporting documentation	Examiner's Initials and date
#1 Date Booster completed for Negative Titer		Examiner's Initials and date
#2 Date Booster completed for Negative Titer		Examiner's Initials and date
Hepatitis B Titer - within 10 years		
Date Titer completed	Results	Examiner's Initials
Hepatitis Series – within 20 years		
#1 Date Booster completed		Examiner's Initials and date
#2 Date Booster completed		Examiner's Initials and date
#3 Date Booster completed		Examiner's Initials and date

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B vaccination at this time. I understand that by refusing to take this vaccination, I continue to be at risk of acquiring Hepatitis B.

Student Signature required: **Date:**

Health Care Examiner's Statement

I have verified that the individual I have examined is the individual on this form and that the above tests/vaccinations were performed in this office/laboratory or I have reviewed any documentation relative to the student's immunization record.

Examiner's Name: (Please Print)_____

Signature of Health Care Examiner:_____

License #_____ Phone:_____ Date:_____

Section 3: Release of Information

In conformance with 20 U.S.C. 123g (Family Education Rights and Privacy Act) and Section 228.093, Florida Statutes, I authorize Broward College and its agents to release and disclose the information contained in this form, including my immunization record, upon request, to a clinical affiliation site

_____I herein **give** permission to duplicate the requested information and release it to the clinical site.

_____I **do not** give permission to duplicate the requested information and release it to the clinical site.

Student Signature: _____ Date: _____

Section 4: Verification of Compliance with Technical Performance Standards

The Health Science Education has outlined specific Technical Performance Standards that serve to inform students of skills and/or physical/psychological demands necessary for program completion and workplace responsibilities.

After review of the Technical Performance Standards for my program of study (Nursing Website):

___ **I have determined that I will be able to perform the standards or essential skills listed.**

___ **I have determined that I will be able to perform the standards or essential skills listed but will require** reasonable accommodation. I have registered with Disability Services and will arrange to meet with the Associate Dean to determine the accommodation necessary.

Student Signature: _____ Date: _____

Section 5: Permission to Render Medical Treatment

In case of serious illness or accident, I give Broward College or its representative(s) permission to secure medical and/or surgical care to include transportation to a physician or hospital of their choice, examination, medication, and surgery that is considered necessary for my good health. I understand that I am responsible for any cost incurred if not covered by the Health Care Agency Affiliation Contract or by the Health Science accident insurance.

Student Signature: _____ Date: _____