Preadmission Health History and Physical for NOVA Allied Health Programs

INSTRUCTIONS TO STUDENT: This form must be filled out by student and a licensed primary care provider: physician, physician's assistant, or nurse practitioner after official acceptance to a NOVA Allied Health program. Physical examinations must be completed and are required prior to placement in the clinical portion of the program. Upon completion, the student will keep the original, and submit a copy to the CastleBranch tracker.

PART I Student: Complete this section before visiting primary care provider. Please print.

Name:_____
First Middle Last

Address:_____
Street City/State Zip Code

NOVA Student ID:_____

Telephone:_____
Home Work Cell

Birthdate:_____
Month Day Year

E-mail Address:_____@email.vccs.edu_____
College Other E-mail Address

NOTE: The student is required to maintain health insurance and/or be responsible for medical expenses incurred during a clinical rotation. Final placement in the clinical portion of your program is contingent on the completion and passing of your drug screen, background check, and physical examination.

PART II **Instructions:** This physical examination must be completed by a primary care provider and an OFFICIAL STAMP affixed on the following page. It includes the measurable Essential Functions/Technical Standards required to successfully practice in the health professions

1. Communication
Essential Function/Technical Standard: Communicate in English, both verbally and in writing

2. Height: _____

3. Weight: _____

4. T:_____P:_____R:_____BP:_____/_____

5. Vision: OD_____OS_____OU_____Corrected?_____Yes_____No_____
Essential Function/Technical Standard: Visual ability sufficient to observe patient/client responses

6. General Appearance:_____

_____

7. Ears:_____
Essential Function/Technical Standard: Hearing ability sufficient to monitor and assess health needs

8. Nose:_____
Essential Function/Technical Standard: Smell sufficient to maintain patients' and environment safety

9. Throat:_____

10. Neck:_____

11. Breasts:_____

12. Chest:_____

13. Cardiovascular system:_____

14. Abdomen:_____

15. GI system:_____

16. GU system:_____

17. CNS/Reflexes:_____
Essential Function/Technical Standard: Gross and fine motor skill abilities

18. Back:_____
Essential Function/Technical Standard: Mobility to stand; sit; squat; turn; bend; lift

19. Extremities: _____
Essential Function/Technical Standard: Tactile (touch) ability sufficient for assessment related to therapeutic intervention

20. Describe any conditions currently being treated:_____

21. Allergies:

Drugs	Medical Supplies i.e. Latex	Other i.e. Food/Seasonal

Primary Care provider:

I have this date given_____a careful physical examination.
Name of Student

Upon completion of this examination I believe to the best of my knowledge this applicant meets the measurable functions/standards without reasonable accommodations.

_____
Printed name of Primary Care Provider Signature of Primary Care Provider Date

STATEMENT FOR STUDENTS REQUESTING ACCOMMODATIONS

Or

I have this date given_____a careful physical examination
Name of Student

Upon completion of this examination I believe to the best of my knowledge this applicant can meet the measurable functions/standards with certain reasonable accommodations. Based on my evaluation, this student will need the following reasonable accommodations:

_____

_____

_____

_____

_____

_____

_____

_____
Printed name of Primary Care Provider Signature of Primary Care Provider Date

STATEMENT FOR STUDENTS REQUESTING ACCOMMODATIONS

Please Print Name: _____

Address: _____
City State Zip

Telephone: _____

Official Stamp_____

PART III Immunization Record Requirements

Immunizations must be documented/completed by a primary care provider. This form and all lab results must be scanned to the immunization tracker at the following address: https://www.castlebranch.com. Students will receive instructions on how to submit results to the immunization tracker after official acceptance to the program.

1	**Measles, Mumps, Rubella (MMR)**	One of the following is required: Two vaccinations **OR** positive antibody titer for all three components (lab report required). If series is in progress submit 1st vaccine and a new alert from CastleBranch will be created for you to complete the series. If any titer is negative or equivocal, a new alert will be created for you to receive one booster shot.	**MMR-2 Vaccinations or one titer/booster:** ☐Date of MMR 1 _____ ☐Date of MMR 2 _____ **or** ☐Date of TITER _____ If titer is negative or equivocal, student must receive a booster shot. Date of Booster _____
2	**Varicella** *Chicken Pox*	One of the following is required: Two vaccinations **OR** positive antibody titer (lab report required) If series is in progress submit 1st vaccine and a new alert from CastleBranch will be created for you to complete the series. If any titer is negative or equivocal, a new alert will be created for you to receive one booster shot.	**VARICELLA-2 Vaccinations or one titer** ☐ Date of Varicella 1 _____ ☐Date of Varicella 2 _____ **or** ☐ Date of TITER _____ If titer is ***negative*** or ***equivocal,*** student ***must*** receive a booster shot. Date of Booster _____
3	**Hepatitis B**	One of the following is required: three vaccinations **OR** a positive antibody titer (lab report required) **OR** declination waiver. If series is in progress, submit to CastleBranch where you are in the series and new alerts will be created for you to complete the series. If the titer is negative or equivocal, a new alert will be created for you to receive one booster shot.	**HEPATITIS B- Series in progress or titer or declination** ☐Date of Hepatitis B-1 _____ ☐Date of Hepatitis B- 2 _____ ☐Date of Hepatitis B- 3 _____ **or** ☐Date of TITER _____ **or** ☐Date of Declination form _____ If titer is ***negative*** or ***equivocal***, student must receive a booster shot. Date of Booster _____
4	**Tuberculosis Skin Test (TST)**	One of the following is required: Two- step TST skin test (1 to 3 weeks apart) **OR** QuantiFERON Gold blood test **OR** if positive results, provide clear Chest X-Ray results. Applicant must undergo annual TST testing to continue in allied health programs.	**TB requirement** ☐Date and final result of Two-step TB test _____ **or** ☐Date and ***negative*** result of QuantiFERON Gold blood test _____ Date and ***negative*** result of chest x-ray _____
5	**Tetanus,Diptheria, & Pertussis (Tdap)**	Submit documentation of a Tdap booster within the past ten years **OR** Td booster within the past two years. The renewal date will be set for ten years if Tdap is submitted or two years if Td is submitted.	☐Date of Tdap booster within the past ten years _____ **or** Date of Td booster within the past two years _____
6	**Influenza**	The following will be required during the current flu season: Documentation of annual flu shot. The renewal date will be set for one year from administered date of vaccine.	See Assistant Dean for date requirements for specific programs.