NOVA | Northern Virginia Community College

Form 125-017
Rev. 6/2016

Preadmission Health History and Physical for NOVA Nursing Programs

INSTRUCTIONS TO STUDENT: This form must be filled out by applicant and a licensed primary care provider: physician, physician's assistant, nurse practitioner. 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 Applicant: Complete this section before visiting primary care provider. Please print.

Name:

____
First Middle Last

Address: ____
Street City/State Zip Code

NVCC Student ID: ____

Telephone: ____
Home Work Cell

Birthdate: ____
Month Day Year

E-mail Address: ____________________@email.vccs.edu____________________
College Other

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/Core Performance Standards required to successfully practice in the health professions

1. Communication
   Essential Functions/Core Performance 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 Functions/Core Performance Standard: Visual ability sufficient to observe patient/client responses

6. General Appearance:____
   ____

7. Ears:____
   Essential Functions/Core Performance Standard: Hearing ability sufficient to monitor and assess health needs

8. Nose:____
   Essential Functions/Core Performance 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 Functions/Core Performance Standard: Gross and fine motor skill abilities

18. Back:____
    Essential Functions/Core Performance Standard: Mobility to stand; sit; squat; turn; bend; lift

19. Extremities:____**Essential Functions/Core Performance 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 Essential Functions/Core Performance 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

The immunization form on the following page must be completed by a primary care provider. This form and all lab results must be faxed or scanned to the following address: https://www.castlebranch.com.

1	**Measles (Rubeola), Mumps, Rubella (German Measles) (MMR)**	One of the following is required: Two doses of the vaccination required at least one month (30 days) apart **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. **NOTE:** Pregnant women or individuals with weakened immune system should **NOT** get vaccine. Documentation from Healthcare Provider is **REQUIRED**.	**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. **NOTE:** Pregnant Women or individuals with weakened immune system should **NOT** get vaccine. Documentation from Healthcare Provider is **REQUIRED**.	**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 (the second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose and at least 4 months after the first dose)**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 __________ 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 or history of positive TB test with no chest x-ray report, provide clear Chest X-Ray results. Applicant must undergo annual TST testing to continue in Nursing and Allied health programs. Bacille-Calmette-Guerin (BCG) vaccination (administered for tuberculosis protection) may cause a false-positive reaction to the TST. Blood tests such as the QuantiFERON Gold to detect TB infection, unlike the TST, are not affected by prior BCG vaccination and are less likely to give a false- positive result.	**TB Requirement** Date and Result of Two-step TB test__________ **OR** Date and ***negative*** result (in mm induration, transverse diameter) of QuantiFERON Gold blood test __________ Date and ***negative*** result of chest x-ray:__________ Date of TB Surveillance Form:__________
5	**Tetanus, Diptheria, & Pertussis (Tdap/Td booster)**	Persons aged 11 years or older but less than 65 years of age who have not received Tdap vaccine or for whom the vaccination status is unknown, should receive a one-time dose of Tdap followed by tetanus and diphtheria toxoids (Td) booster every ten years thereafter.	**Tdap/Td Vaccine** Date of one-time Tdap within the past ten years __________ **OR** Date of Td booster within the past ten years__________
6	**Influenza**	One of the following is required: Documentation of a flu shot administered during the current flu season **OR** a declination waiver. The renewal date for the flu shot will be annually prior to the start of the flu season.	Date of flu shot __________ Date of Declination form__________