Required documents to be uploaded

Students cannot attend the clinical portion of the program without completed Medical Documents and a valid signed CPR card uploaded to Complio

First: Required Documents Instructions

Medical Form & Supplemental Medical Guidelines Form

- A licensed physician, physician assistant or nurse practitioner must complete the Medical Form and Supplemental Medical Guidelines Form. They must sign and date the form and provide their license number.

Immunization Form

- This form must be complete, current, and verified by a physician, physician assistant, nurse practitioner or nurse. They must sign and date the form and provide their license number.
- Please Note: It is imperative that the Immunization Form (immunizations, titers, etc.) be completed as specified. If your Health Care Provider suggests alternate ways of meeting the specified requirements, please contact the Nursing Department to have the suggestions approved. Our requirements are mandated by our clinical agencies and we must adhere to their strict guidelines.

  Holistic vaccines are not acceptable.

CPR Certification

- Current CPR (for Health Care Provider) certification is required for all nursing students. The CPR certification must be from an *American Heart Association approved program*.

Second: Review of Required Documents Prior to Uploading

- Check for completeness. All vaccines and/or immunity must be documented with a date.
- Note Hepatitis B vaccine requirement must be met by HepB series of 3 vaccines or a positive Titer. The series must be completed within six (6) months of the first (1st) vaccine. The second (2nd) vaccine is given within one to two months of the first (1st) vaccine. A minimum of the first (1st) HepB vaccine must be documented to begin the program.

Third: Upload the Following Documents

- Medical Form *(2 pages)* Use the date you sign the form
- Supplemental Medical Guidelines Form *(1 page)* Use the date the doctor signs the form
- Immunization Form *(1 page)*
- Copy of your *American Heart Association approved* CPR (Cardio-Pulmonary Resuscitation) Certification for Health Care Provider. (Copy of both front and back, **with signature** is required). *(1 page)*
- Influenza Vaccination form (*1 page)*

Medical Form – Palomar College

To the Physician: Palomar College requires a physical examination from students enrolling in the Nursing Program. A frank statement of your knowledge of this student's health (mental and physical) will be greatly appreciated. This report goes directly to the Nursing Education Department and will be released only to authorized college and clinical facilities and hospital personnel.

Student's Name ____
(Please Print) Last First Initial

Disclosure and Certification Statements *(Applicant's signature required below)*
I hereby grant permission for the release/disclosure of health screening medical information between and among authorized college, clinical facilities and hospital personnel.

______________________________ ______________
Applicant's Signature **Date**

Health History – to be completed by student	**Circle Yes or No** (where applicable)	
1. Have you ever been hospitalized?	Yes	No
a. List health problem:	Date:	
b. List surgeries performed:	Date(s):	
2. Are you under a physician's care now?	Yes	No
a. Give name of personal M.D.		
b. List health problems:		
3. Are you taking medications on a regular basis?	Yes	No
a. List:		
4. Do you have any allergies?	Yes	No
a. List medications you are allergic to:		
b. List other allergies: (food, pollen, animal, dust):		
5. Have you had a back or neck or wrist injury?	Yes	No
6. Have you had an injury to any muscle, bone, ligament or tendon?	Yes	No
a. Was medical attention or surgery required?	Yes	No
b. Please explain:		
7. Do you smoke? Number of packs per day:	Yes	No
Please indicate if you or a family member have had:	Self	Family Member
1. Hypertension (high blood pressure)		
2. Heart disease		
3. Diabetes		
4. Cancer		
5. Tuberculosis		
6. Seizure disorder		
7. Asthma		
8. Chickenpox		
9. Drug and/or alcohol abuse		

Medical Form *(pg. 2 continued)*

Required Information Below To be Completed by the Physician:

BP______________ P______________ R_____________ Ht.______________ Wt._________________

Required Information:

Vision: Normal _________ Abnormal _________

R Eye 20/ L Eye 20/

Glasses ☐ Yes ☐ No C/Lens ☐ Yes ☐ No

Hearing:	Normal	Abnormal
R Ear	_________	_________
L Ear	_________	_________

Physician Exam:

	Normal	Abnormal	Description:
1. Gen Appearance	_______	_______	____________________
2. Skin	_______	_______	____________________
3. Nodes	_______	_______	____________________
4. Skull	_______	_______	____________________
5. Ears	_______	_______	____________________
6. Eyes	_______	_______	____________________
7. Nose	_______	_______	____________________
8. Neck & Thyroid	_______	_______	____________________
9. Chest	_______	_______	____________________
10. Abdomen	_______	_______	____________________
11. Hernia Check	_______	_______	____________________
12. Musculoskeletal	_______	_______	____________________
a. Neck	_______	_______	____________________
b. Back	_______	_______	____________________
c. Shoulders	_______	_______	____________________
d. Knee	_______	_______	____________________
e. Ankle	_______	_______	____________________
f. Feet	_______	_______	____________________
g. Other	_______	_______	____________________
13. Neurological	_______	_______	____________________

Comments: ____

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Supplemental Medical Guidelines Form – Palomar College

Nursing students must be able to do total patient care in all nursing areas without physical, emotional or psychological limitations. Written documentation of complete recovery from any previous injury and/or illness must be provided. Following is a brief description of the type of physical activities that students will perform while working with patients in the hospital.

- Moderate to heavy lifting and carrying (20-40 pounds).
- Pushing, pulling, bending and kneeling around patients using various types of hospital equipment such as wheelchairs, gurneys, lifting devices and specialized beds.
- Fine motor dexterity using both hands while preparing medications and manipulating a variety of instruments and assessment devices.
- Rapid mental processing and simultaneous motor coordination.
- Extensive periods of walking and standing.
- Visual discrimination including depth perception and color vision.
- Ability to hear the spoken word in settings where other sounds are present.
- Working with hands in water (frequent hand washing is required).
- Working with various materials and substances to which some individuals may be allergic.
- Hyper vigilance when working with potentially agitated patients.
- Casts, splints, braces are not allowed in clinical settings.

Mark the appropriate box below:

☐ After reviewing the "Supplemental Medical Guidelines" listed above and based on findings from the patient's history and physical exam, I certify that the above student is physically and mentally capable of fully participating in Palomar College's Nursing Program.

☐ The following health problems(s) should be further evaluated **PRIOR** to participation in a clinical assignment:

____

____

____

__________________________________ ________________________
Examiner's Signature Date

License #______________________

*Please attach either a business card from examiner or an office stamp

*

Immunization Form – Palomar College

Student's Name ____

1.	**Tuberculin Test (PPD) <u>Required Annually</u> – Choose A or B or if C applies to you** **Note:** Some vaccines can interfere with the 2-Step PPD. If a 2-Step PPD is required (2 PPD skin tests at least 1 week apart), complete the 2-Step before having any other vaccines.

A. Dates of two (2) <u>documented</u> negative PPDs *(current year and year prior without expiring in between)*

1st PPD Date Read: _______________ Result: negative ____ positive ____

2nd PPD Date Read: _______________ Result: negative ____ positive ____

- If your last documented negative skin test was within one year, and a PPD was not done the year prior or has expired, a second, **single PPD** test will be needed
- If more than one year has elapsed since your last documented negative skin test, the **2-step procedure (2 PPD skin tests at least one week apart)** is required. **(Please complete this before receiving any other vaccines)**

OR

B. A one-step BAMT (Blood Assay for Mycobacterium Tuberculosis) or Quantiferon TB Gold

Date – If verified negative: _________________________

C. History of a Positive Skin Test: *(both A and B)*

Date of negative chest x-ray (**within 6 months** of starting the Nursing Program) ____________________

- **A copy of the negative chest x-ray results must be submitted with this form**
- A <u>symptom report signed by your doctor</u> will be required <u>annually</u> instead of the PPD test or chest x-ray

2.	**Measles, Mumps and Rubella (MMR) Vaccine or Positive Titer Required**

A. Two (2) MMR vaccines: Date given 1st: ____________________ Date given 2nd: ___________________

OR

B. Date of Positive Serum Titers: Measles_____________ Mumps______________ Rubella_____________

(If not immune, vaccine should be given)

3.	**Hepatitis B Vaccine: HepB (only) <u>OR</u> Twinrix (A & B combo) <u>OR</u> Positive Titer Required** (May begin program with 1st vaccine then present proof of second and third doses as required)

A. Hepatitis B vaccine: (Please indicate which one given) ☐ Hep B ☐ Twinrix A/B combo

Date given 1st: _______________ Date given 2nd:______________ Date given 3rd:_______________

OR

B. Date of Positive Titer: _____________________ *(If not immune, vaccine should be given)*

4.	**Varicella (Chicken Pox) Vaccine or Positive Titer Required**

A. Two (2) Varicella vaccines: Date given 1st: _________________ Date given 2nd: ___________________

OR

B. Date of Positive Titer: _____________________ *(If not immune, vaccine should be given)*

5.	**Tetanus, Diphtheria, Pertussis (Tdap) Vaccine Required**

A. Tdap vaccine: Date given: ___________________ Td(pertussis) booster: Date given: ______________

6.	**Influenza Vaccination Required Seasonally (Fall)**

A. Influenza Vaccination: Date given: ____________________

B. Influenza Declination form: Date signed: __________________ (Fill out form)

Form Completed By:

Name & Title ___________________________________ License # ____________________ Date_____________

Note:These requirements are mandated by our clinical agencies and we must adhere to their strict guidelines. Please contact the Nursing Department if you have questions regarding these requirements. Holistic vaccines are not acceptable.

Required Annual Tuberculosis Symptom Review Questionnaire

for ONLY positive skin test results

Name____

DOB________________________________

Record documented positive Intradermal (Mantoux) reaction and follow-up chest x-ray results below:
(Attach a copy of your latest Chest X-ray results)

Mantoux PPD: ________ mm/Date: ________ Chest x-ray date: ________ ☐ Normal ☐ Abnormal

INH Preventive Therapy ☐ Took ( ) months of INH ☐ Refused INH ☐ Not eligible

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Please complete the following:

Have you experienced any of the following symptoms recently?

Yes	No	
☐	☐	1. Cough for more than two weeks in duration
☐	☐	2. A productive cough (bringing up sputum every day for one week or more)
☐	☐	3. Fatigue or listlessness for more than two weeks in duration
☐	☐	4. Fever for more than one week in duration
☐	☐	5. Night sweats
☐	☐	6. Unexplained weight loss of 8 pounds or more

Student Signature ____ Date ____________________

To be completed by Health Care Provider (check one)

☐ 1. **TB Clearance given.** Student reminded to report TB symptoms if they occur.

☐ 2. Problem noted. (See comments below)

Comments:

Health Care Provider Signature ____

Medical ID #_________________

Title ____ Date _____________________