

## **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.**

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### **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**

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

<b>Review of Systems / Medical History — please check all that apply</b>			
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		Splenectomy	
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.**

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

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**Allergies: \_\_\_ None    \_\_\_ Latex    \_\_\_ Penicillin/Ampicillin    \_\_\_ Other**

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**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.

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**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?** YES NO  
If yes, please specify limitation:

**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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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
<p>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.</p>		
<b>Student Signature required:</b>		<b>Date:</b>
Health Care Examiner's Statement		
<p>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.</p>		
Examiner's Name: (Please Print) _____		
Signature of Health Care Examiner: _____		
License # _____ Phone: _____ Date: _____		

## **BROWARD COLLEGE NURSING PROGRAM ADMISSION MEDICAL HISTORY & PHYSICAL EXAMINATION**

### **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: \_\_\_\_\_