

**August 1<sup>st</sup> is the deadline for completion and submission of this form. Students cannot begin clinical experiences until all components are completed.**

## **MILES COMMUNITY COLLEGE REGISTERED NURSING BASIC HEALTH SCREENING**

The purpose of the Basic Health Screening is to:

- Ensure that students have met the basic health requirements of contracted healthcare facilities providing student clinical experiences
- Ensure that students are personally protected for practice in the healthcare delivery environment.

The health screening must be performed by a licensed primary health care provider, such as a:

- Physician
- Nurse practitioner
- Physician's Assistant

**This information will not be released for secondary submission to another agency or employer.**

### **TO BE COMPLETED BY STUDENT**

#### **DEMOGRAPHICS**

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Permanent Mailing Address \_\_\_\_\_

Date of birth \_\_\_/\_\_\_/\_\_\_ Gender F M (circle one)

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email \_\_\_\_\_

#### **PERSON TO NOTIFY IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

#### **HEALTH AND HOSPITAL INSURANCE**

NAME OF INSURANCE COMPANY \_\_\_\_\_

ADDRESS OF INSURANCE COMPANY \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

**If you do not have health insurance, obtain a Health Insurance waiver form from the Nursing Administrative Assistant or on the nursing website at <http://www.milesc.edu/Programs/Nursing/>. The waiver must be signed, notarized, and accompany this record.**

Discovery of any incorrect information or falsification of information on the Basic Health Screening form may lead to revocation of acceptance and denial of continuation in the Miles Community College Nursing Program

#### **CPR CERTIFICATION**

I have attached a copy of my current CPR Certification. Yes No (Circle one)

My CPR certification is current and valid until \_\_\_\_\_(date)

#### **CNA REQUIREMENT**

I have taken the required CNA course or have attached a copy of my CNA license . Yes No

Date Completed/Licensed \_\_\_/\_\_\_/\_\_\_

## TO BE COMPLETED BY STUDENT

### MILES COMMUNITY COLLEGE HEPATITIS B VACCINATION POLICY

Hepatitis B illness is a potentially fatal disease caused by a virus which can be transmitted through mucus membranes, sexually, perinatally and through non-intact skin. The highest concentration of the virus is in the blood: thus exposure to blood is the most dangerous and "needle sticks" constitute the highest occupational risk for health care workers. Because health care workers are at two to four times greater risk than the general public, The Center for Disease Control has recommended immunization for all health care workers in high risk areas.

Your clinical experience will be in a wide variety of health care settings. This may increase your risk for accidental exposure to Hepatitis B virus. It is therefore **strongly recommended** that you receive vaccination to protect you from this disease.

Vaccination requires three separate vaccines received over a period of six months. Complete immunity will not be established until the end of this time period. It is to your advantage, therefore, to initiate your vaccination early so that you will have complete immunity when you begin your major clinical experiences.

This form must be submitted with either Section A or Section B completed.

#### SECTION A

I have initiated my Hepatitis B Vaccine, which will be completed by \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature) (Date)

OR

I have completed my Hepatitis B Vaccine:

1<sup>st</sup> Dose: \_\_\_\_\_ (Date) 2<sup>nd</sup> Dose: \_\_\_\_\_ (Date) 3<sup>rd</sup> Dose \_\_\_\_\_ (Date)

Reactive titer attached \_\_\_\_\_ (Date)

\_\_\_\_\_  
(Signature) (Date)

#### SECTION B

I understand the risks, and I choose **NOT** to protect myself with hepatitis B vaccination at this time.

\_\_\_\_\_  
(Signature) (Date)

# TO BE COMPLETED BY STUDENT

## HEALTH HISTORY RECORD

HEALTH HISTORY		
HISTORY	YES	NO
Arthritis		
Rheumatic Fever		
Tonsillitis		
Hay Fever		
Epilepsy		
Tuberculosis		
Bleeding Disorders		
Heart Disease		
Urinary Disorders		
Asthma		
Dysmenorrhea		
Emotional Disturbances		
Cancer		
Eczema		
Mononucleosis		
Hepatitis (A-B)		
Handicap		
Latex Allergy		
Other		

# TO BE COMPLETED BY HEALTH CARE PROVIDER

An official copy of Immunization/Vaccination can be used for validation as long as actual dates are listed. If no records of childhood immunizations are available, student may verbally validate.

## REQUIRED IMMUNIZATION RECORD

Student's Name: \_\_\_\_\_

REQUIRED IMMUNIZATIONS	
VACCINATIONS	DATE/S
Polio	
DPT Inoculation	
Tetanus/Diphtheria Booster (last 5 yrs) <b>OR</b> TDap (last 10 years)	
Measles Vaccine or Reactive Titer	
Rubella Vaccine or Reactive Titer	
Mumps Vaccine or Hx of disease	
Varicella Titer or Hx of Chicken Pox	
Hepatitis B Vaccines or Reactive Titer	
Hepatitis A Vaccines (recommended)	
Meningococcal Meningitis ( recommended)	
<p>PPD (Tuberculin Skin Test)</p> <p style="margin-left: 40px;">Date given: _____</p> <p style="margin-left: 40px;">Given by: _____</p> <p style="margin-left: 40px;">Date read: _____</p> <p style="margin-left: 40px;">Read by: _____</p> <p style="margin-left: 40px;">Results:</p> <p style="margin-left: 80px;">Negative: _____</p> <p style="margin-left: 80px;">Positive: * _____</p> <p><b>+If PPD is positive a doctor's report of a current chest x-ray is required.</b></p>	

**PLEASE CONTINUE TO NEXT PAGE**

# TO BE COMPLETED BY HEALTH CARE PROVIDER

## PAST HEALTH

Accident or Injuries:

Serious or Chronic Physical and/or Mental Illnesses:

Hospitalization/Surgeries:

\*Allergies:

bananas \_\_\_\_ avocados \_\_\_\_ kiwi fruit \_\_\_\_ poinsettias \_\_\_\_

Asthma \_\_\_\_

**\*If you have checked any of the above, we strongly recommend a Latex Allergy Blood Test.**

Current Medications:

Other:

## PHYSICAL EXAMINATION

Pulse \_\_\_\_\_ Resp \_\_\_\_\_ BP \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_

Throat \_\_\_\_\_ Teeth \_\_\_\_\_ Neck \_\_\_\_\_

Lymph \_\_\_\_\_ Lungs \_\_\_\_\_

Breasts \_\_\_\_\_ Heart \_\_\_\_\_ Abdomen \_\_\_\_\_

Spine and Back \_\_\_\_\_ Extremities \_\_\_\_\_ Skin \_\_\_\_\_

Hernia \_\_\_\_\_ Date of last GYN exam (if applicable) \_\_\_\_\_

Reflexes \_\_\_\_\_ Mental State \_\_\_\_\_

Motor \_\_\_\_\_ Sensory \_\_\_\_\_

## HEALTHCARE PROVIDER, NAME, ADDRESS and PHONE NUMBER

---

---

---