

August 1st is the deadline for completion and submission of this form. Second year and readmitted students cannot begin clinical experiences until all components are completed.

MILES COMMUNITY COLLEGE REGISTERED NURSING HEALTH INFORMATION UPDATE

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

TO BE COMPLETED BY STUDENT

Name: Last _____ First _____ Middle _____

Permanent Mailing Address _____

Home Phone _____ Cell Phone: _____ Email _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name _____ Relationship _____

Address _____ Home Phone _____ Work Phone _____

CPR CERTIFICATION

I have attached a copy of my current CPR Certification. Yes No (Circle one) **Valid until** _____ (date)

TO BE COMPLETED BY HEALTH CARE PROVIDER

The health screening must be performed by a licensed primary health care provider, such as a Physician, Nurse practitioner, Registered Nurse, or Physician's Assistant.

Allergies

Are you allergic to any of the following (Check any you have had a reaction to)

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> bananas | <input type="checkbox"/> kiwi fruit |
| <input type="checkbox"/> avocados | <input type="checkbox"/> poinsettias |

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

Other allergies/reactions: _____

Do you have asthma? _____

PPD (Tuberculin Skin Test)

Date given: _____

Given by: _____

Date read: _____

Read by: _____
(signature)

Results:

Negative: _____

Positive: * _____

***If PPD is positive a doctor's report of a current chest x-ray is required.**

Pulse _____ Blood Pressure _____

Health changes since previous Basic Health Screening: _____

Student Signature: _____ Date _____

Health Care Provider Name _____ Signature: _____ Date _____
(Must be R.N., N.P., P.A., or physician)

Health Care Provider Address _____