Golden West College School of Nursing
Medical Exam Information Sheet

History and Physical Clearance
A report, signed by the physician, physician's assistant, or nurse practitioner, shall be provided to the nursing program. This report shall indicate that the student does not have any health condition(s) that would create a hazard to themselves, employees, or patients (Title 22).

The Test Listed Below Are Required Tests. X-rays must be done no longer than 1 year ago. Lab reports for titers must have been dated within the past 3 years.

Urinalysis – An analysis of the components of urine.
CBC – Complete Blood Count
VDRL or RPR – Diagnostic test for Syphilis, reported as reactive or non-reactive.

TB Test (PPD) – Diagnostic test for Tuberculosis is required.

- All nursing students are required to have one of the following: an initial two step TB screening, QuantiFERON TB Skin Test or a chest x-ray upon admission to the program.
- If the first test reading is positive, no further skin testing is done. The person would then require follow-up by their health care provider including a chest x-ray to rule out active disease and evaluation for appropriate medication and follow-up therapy.
- If the first test reading is negative, the second test is performed 1-3 weeks later.
- If the second test is positive the person is classified as "previously infected" and cared for according.
- For persons who have documentation of a previous positive PPD, no skin testing is performed and follow-up including health evaluation, symptom screening, and periodic chest x-rays is required per current CDC guidelines. Symptom screening review is to be completed yearly.

Tetanus, Diphtheria, Pertussis – Individuals who have had a primary series of Tetanus/Diphtheria/Pertussis containing product (TDP, Tdap, DT, and Td) should receive a booster every 10 years and a onetime dose of Tdap is recommended for all health care providers under the age of 65.

Varicella – Proof of positive titer is required. If results are negative, 2 doses of varicella or booster are recommended unless medically contraindicated. Vaccines are given one month apart.

Hepatitis B (Vaccination series, positive serology or waiver) – Proof of positive titer is required.

- If anti-HBs are positive no further serologic testing or vaccination is recommended.
- If anti-HBs are negative the patient is unprotected from hepatitis B virus (HBV) infection; revaccinate with a 3-dose series or booster.
- Give 3 dose series: dose #1 now, dose #2 in 1 month, dose #3 at least 2 months after second dose (at least 4 months after the first dose) or HEPLISAV B 2 dose series.

Measles, Mumps, Rubella (MMR) – Proof of positive titer is required. If results are negative, 2 doses of MMR are recommended 4 weeks apart unless medically contraindicated. If planning to receive MMR immunization have PPD completed first.

Influenza (When Available) – Give 1 dose of influenza vaccine annually or declination form is needed. Make sure the lot # is listed on documentation.

Medical Exam Information Sheet (continued)

In the best interest of our students, please be aware that certain physical, emotional and learning abilities are necessary in order to protect the individual student's well-being and provide for the safety of each patient/client placed in his/her care. The following are basic physical and emotional abilities required of the student for success in the Registered Nursing Program:

Standing/Walking - Much of the workday is spent standing. Approximate walking distance per shift: 3-5 miles while providing care, obtaining supplies and lab specimens, monitoring and charting patient response, and managing/coordinating patient care.

Lifting - Some of the work day is spent lifting from floor to knee, knee to waist, and waist to shoulder levels while handling supplies (at least 30 times per shift). These supplies include trays (5 to 10 pounds) and equipment (5 to 35 pounds). The nurse must also assist with positioning patients in bed or moving patients (average patient weight is 150 - 200 pounds).

Carrying - Some of the workday is spent carrying charts, trays and supplies (5 to 10 pounds).

Pushing/Pulling - A large part of the workday is spent pushing/pulling while moving or adjusting equipment such as beds, wheelchairs, furniture, intravenous pumps and emergency carts.

Balancing and Climbing - Part of the workday is spent climbing stairs. The nurse must always balance self and use good body mechanics while providing physical support for patients/clients.

Stooping/Kneeling - Some of the workday is spent stooping/kneeling while retrieving and stocking supplies and medications, assessing equipment attached to patients/clients and using lower shelves of carts.

General Extremity Motion (upper and lower extremities) - It is evident from the previous statements that extremity movement is critical. Movement of the shoulder, elbow, wrist, hand, fingers and thumb is required throughout the workday. Movement of the hip, knee, ankle, foot and toes are also required throughout the workday. It is necessary for the student to be able to turn, flex and extend his/her neck.

Hearing - A majority of the workday requires an ability to hear and correctly interpret what is heard. This not only includes taking verbal or telephone orders and communicating with patients, visitors and other members of the health care team; but also involves the physical assessment of cardiovascular, pulmonary and gastrointestinal sounds and the analysis of patient monitor alarms. If assisted devices for hearing are needed, an explanation in the hearing section of the Physician/Nurse Practitioner form is required and documentation must be attached.

Emotional- A student must be emotionally stable under normal and stressful circumstances encountered in the health care setting.

To enroll in nursing coursework, the selected applicant needs to be free from any physical, behavioral, emotional or mental condition that would adversely affect his/her behavior so as to create an undue risk or harm to himself or herself, other students, instructors, or other persons. If an applicant disputes a determination that he/she is not free from such a physical, behavioral, emotional or mental condition, the Program Director shall confer with the Nursing Admission/Retention Committee. The applicant may be required, at his/her expense, to be examined by either a licensed physician and/or surgeon, or by a licensed clinical psychologist. If the health practitioner deems the applicant safe to participate in the nursing program, the information is shared with the Admission/Retention Committee and the committee determines if the applicant is granted admission.

The above conditions also apply to students who are currently enrolled in Nursing Program. Maintenance of good health (physical, behavioral and emotional) is essential for continuation, and the criteria and conditions explained above are operative throughout the student's time in the program.

Student Medical Form

GOLDEN WEST COLLEGE SCHOOL OF NURSING

Name: _____ Student ID# _____
(Last) (First) (Initial)

Phone # ( ) _____ Home

Age: _____ Birth Date: _____ ☐ M ☐ F ☐ Other

( ) _____ Cell

Emergency Contact: _____

Relationship _____Cell ( ) _____ Home ( ) _____

HEALTH HISTORY TO BE COMPLETED BY STUDENT
PLEASE ANSWER ALL QUESTIONS BY CHECKING "YES OR "NO" AND FILL IN THE BLANKS
(FALSIFIED INFORMATION MAY BE GROUNDS FOR TERMINATION FROM THE NURSING PROGRAM)

1. Have you ever been hospitalized?..... ☐ Yes ☐ No
   a. List all Health Problems _____ Date:_____
   b. List previous Operations Performed _____ Date:_____

2. Are you under physician's care now?..... ☐ Yes ☐ No
   a. List name of personal M.D._____
   b. List all Health Problems_____
   c. Are you taking medication on a regular basis?..... ☐ Yes ☐ No
      List: _____

3. Do you have any latex allergies?..... ☐ Yes ☐ No

4. Do you need any assisted devices? ..... ☐ Yes ☐ No
   Please explain: _____

5. Do you have or have you had any back injuries? Is yes, date(s) _____ ☐ Yes ☐ No
   a. Have you had an injury to any muscles, bones, ligaments or tendons?..... ☐ Yes ☐ No
   b. Was medical attention or surgery required?..... ☐ Yes ☐ No
   Please explain: _____

6. Please indicate if you or a family member have had or received treatment for:	Self	Family Member
Hypertension (High blood pressure)……	☐	☐
Heart disease……	☐	☐
Diabetes……	☐	☐
Cancer……	☐	☐
Tuberculosis……	☐	☐
Seizure disorder……	☐	☐
Asthma……	☐	☐
Depression ……	☐	☐
Psychiatric disorder……	☐	☐
Learning Disability……	☐	☐
Inappropriate use of alcohol, narcotics, other drugs……	☐	☐

Student Medical Form

GOLDEN WEST COLLEGE SCHOOL OF NURSING

I certify that I have:

Visual acuity, with or without corrective lenses. This includes but is not limited to the ability to complete a patient assessment, read small print, visualize and interpret monitors, and equipment calibrations. Yes___ No____

Hearing ability with or without auditory aids to understand the normal speaking voice without viewing the speaker's face. This includes but is not limited to hearing monitor alarms, emergency signals, patient call bells, and stethoscope sounds originating from the patient's blood vessels, heart, lungs, and abdomen. Yes___ No____

Physical ability to stand for prolonged periods of time and a reasonable level of strength and endurance. This includes but is not limited to the ability to lift a minimum of 50 pounds, perform cardiopulmonary resuscitation, lift patients, move from room to room, maneuver in small spaces, and complete twelve-hour shifts. Yes___ No____

Ability to communicate effectively orally, aurally, and in writing. This includes but is not limited to the ability to speak clearly and understandably to members of the health care team, patients, and families. The student must possess the ability to write legibly and professionally and use effective listening skills. Yes___ No____

Manual dexterity, strength, and fine motor skills. This includes but is not limited to the ability to utilize sterile technique, prepare and administer medications, and perform other nursing procedures/skills. Yes___ No____

Reliable personal transportation and ability to attend all classroom and clinical experiences, both on and off campus. Yes___ No____

A normal level of health and immunity. This includes but is not limited to the ability to tolerate immunizations and to work with a wide variety of potentially contagious patients. Yes___ No____

Ability to function safely and professionally under various stressful conditions. Yes___ No____

Eligibility to meet California Board of Registered Nursing Licensure Requirements. This includes but is not limited to passing a criminal background check and drug and alcohol screening. (Please be aware that some criminal history may preclude an individual from licensure eligibility.) Some clinical sites or health care facilities may have more stringent rules regarding citizenship, which may preclude non-citizens from completing those clinical experiences. Yes_____ No_____

If you have answered "no" to any of the above, explain your limitations in detail on a separate sheet of paper.

Do you have any other conditions which might interfere with your ability to practice nursing?
Yes _____ No _____

DISCLOSURE AND CERTIFICATION STATEMENTS:

I hereby grant permission for the release/disclosure of information contained in the medical examination and health screening forms between and among appropriate college staff and clinical facilities whenever necessary for the evaluation of my fitness. I certify that my answers ate true and complete to the best of my knowledge for all pages of this application. I understand that false or misleading information in mu application my result in denial of admission and/or dismissal from the nursing program.

Student Signature _____ **Date** _____

Physician/Nurse Practitioner Form

GOLDEN WEST COLLEGE SCHOOL OF NURSING

Student Name: _____ Date of Birth: _____/_____/_____

FOR PHYSICIAN/NURSE PRACTIONER USE ONLY – All SECTIONS MUST BE COMPLETED
(**Not Applicable** or **Defer** will not be accepted) (**Abnormal** may require documentation, follow-up and clearance)

BP _____ P _____ R _____ HGT _____ WGT _____

VISION/HEARING TEST:	**Normal**	**If significantly abnormal related to working as a RN student nurse, Please explain and provide documentation:**
Vision	☐	_____
Hearing	☐	_____

LAB RESULTS:	**Normal**	**If significantly abnormal related to working as a RN student nurse, Please explain and indicate if follow up is needed:**
Urinalysis	☐	_____
CBC	☐	_____
VDRL/RPR	☐	_____

PHYSICAL EXAM:	**Normal**	**If significantly abnormal related to working as a RN student nurse, Please explain and indicate if follow up is needed:**
General/Appearance	☐	_____
Skin	☐	_____
Ears	☐	_____
Eyes	☐	_____
Nose	☐	_____
Oropharynx	☐	_____
Neck & Thyroid	☐	_____
Chest	☐	_____
Cardiovascular	☐	_____
Abdomen	☐	_____
Hernia Check	☐	_____
Musculoskeletal	☐	_____
Neurological	☐	_____

☐ 1. No indication upon history and physical exam, which would prohibit this student's participation in the Nursing Program including clinical assignments.

☐ 2. The following health problem(s) need to be evaluated or treated prior to participation in the Nursing Program including clinical assignments: _____
_____

_____ _____ _____
Physician/Nurse Practitioner Signature **Print Name** **Date**

Office Stamp (Required)

RN/Provider Form

GOLDEN WEST COLLEGE SCHOOL OF NURSING

Name: _____ Date of Birth _____/_____/_____
(Last) (First) (Initial)

FOR RN/PROVIDER USE ONLY – All SECTIONS MUST BE COMPLETED

TB Screening – 2 Step TB Test **OR** QuantiFERON TB Gold Test required unless Previous Positive PPD.

- **1st PPD:** Date Given:_____ Date Read:_____ Result: Indur. _____ mm ☐Neg ☐Pos
- **2nd PPD**: (given 1 - 3 weeks from the first):

  Date Given:_____ Date Read:_____ Result: Indur. _____ mm ☐Neg ☐Pos

  Or QuantiFERON TB Gold Test -

- Date Given: _____ Date Read: _____ Result: _____

If PPD POSITIVE: Date of CXR _____ Result of CXR: ☐ No active disease ☐Other (attach report)
Symptom Review:☐ Neg ☐Pos ☐Pt. receiving LTBI tx OR☐Pt. evaluated for LTBI tx, but not a candidate (see letter)

Positive Titers are required for MMR, Varicella and Hepatitis B. If the results are negative, the applicable immunization or booster is required with a follow up Titer to prove immunity.

Rubeola (Measles) – Laboratory evidence of immunity _____date

As applicable: Post Titer Repeat Vaccine: 1st dose (first dose given) _____date 2nd dose (4 wks later)_____date

Mumps – Laboratory evidence of immunity _____date

As applicable: Post Titer Repeat Vaccine: 1st dose (first dose given) _____date 2nd dose (4 wks later)_____date

Rubella (German measles) – Laboratory evidence of immunity _____date **OR**

As applicable: Post Titer Repeat Vaccine: 1st dose (first dose given) _____date 2nd dose (4 wks later)_____date

Varicella (Chickenpox) – Laboratory evidence of immunity _____date **OR**

As applicable: Post Titer Repeat Vaccine: 1st dose (first dose given) _____date 2nd dose (4 wks later)_____date

Hepatitis B – Laboratory evidence of immunity _____date **OR**

As applicable: Post Titer Repeat Vaccine: 1st dose _____date 2nd dose _____date 3rd dose _____date

Tdap date: _____

_____ _____ _____
RN/Provider Signature Print Name DATE

Office Stamp (Required)