Virginia Western Community College
Nurse Aide Program
Medical Examination Form – Nurse Aide

Dear Health Care Provider and Future Nursing Student:

Take a few moments to read the following to achieve compliance with the Medical Exam Form – Nursing. **Failure to complete the form completely and correctly can prohibit the student from attending clinical.**

Name of Applicant: _____
(Last Name) (First Name) (Middle Name)

Address: _____
(Number and Street) (City) (State) (Zip Code)

Phone #: _____
(Best to reach you) (Alternate)

Date of Birth: _____ **Student ID:** _____
(Month/Day/Year)

Personal Information: ***To be completed by the student. (completed form due on the first day of class)***

Please print clearly. **Use a black or dark blue ink pen.** Please use full legal name for signature, not nickname.
If you have a medical condition that requires ongoing care or treatment, ask the Health Care Provider to send a summary to the Nursing Program office or attach it to the Medical Examination form.

SIGNIFICANT FAMILY MEDICAL HISTORY (Please include heart or kidney disease, cancer, hypertension, diabetes, mental or nervous disorders, and other chronic illnesses of your close family members.)

_____
_____
_____

MEDICAL HISTORY: - *Check all that apply to you:

☐ High Blood Pressure	☐ Heart Disease	☐ Dizziness	☐ Arthritis	☐ Stomach Ulcers
☐ Cancer	☐ Headaches	☐ Depression	☐ Seizures	☐ Colitis
☐ Kidney Disease	☐ Muscle Weakness	☐ Diabetes	☐ Asthma	☐ Neuro Disorders

*Please explain any checked items.

_____
_____

Describe any hospitalizations; including operations (provide dates). _____
_____
_____

Describe any injuries requiring medical attention. _____
_____

Reproductive history (pregnancies, miscarriages, live births) _____
_____

List any allergies and the reaction that occurs.

Food _____
Medications _____
Environmental _____

Are you currently taking any medication?

☐ Yes ☐ No

If yes, Please specify _____

I swear the above medical history is complete and accurate to the best of my knowledge.

Student/Parent Signature (if student is under 18 years of age, parent must sign:_____

Student Name: _____ EMPL ID: _____

REQUIRED PHYSICAL

TO BE COMPLETED BY a Medical Doctor or Nurse Practitioner (completed form due on the first day of class)

Height _____ Weight _____ **Date of Physical:**_____

Visual Acuity Left _____Right_____ with Correction Yes ☐ No ☐

HEENT _____

Lungs _____

Heart _____

Heart Rate _____ Blood Pressure _____ Respiration __________

Breasts _____

Abdomen _____ Hernia _____

Back _____ Posture _____

Extremities _____

RECOMMENDATIONS: _____

_____

_____

_____

_____

_____

Attending Physician Printed Name: _____

Attending Physician Signature: _____

Facility Name: _____

Address:_____

Phone#:_____**Fax #:** _____**Email:**_____

Student Name: _____ EMPL ID: _____

REQUIRED IMMUNIZATIONS AND TESTS

Immunizations/Skin Test: ***To be completed by a Health Care Provider(completed form due at orientation)*** .

MMR/Rubella: The student **must have a Rubella titer drawn and the results documented** on the form. In the event, that the student's rubella titer is negative, the student **must** receive the appropriate vaccination(s). Please note if only one or both are necessary.

MMR /Rubella: Titer _____ result _____ ☐ positive ☐ if negative Vaccination #1 _____ #2 _____
(Date) (Date) (Date)

Titer Result Read By: _____ **Title:** _____

If negative **#1 Given By:** _____ **Title:** _____

Chicken Pox/ Varicella: The student **must have a Varicella titer drawn and the results documented** on the form. In the event, that the student's Varicella titer is negative, the student must receive the Varicella vaccinations.

Chicken Pox: Titer _____ result _____ ☐ positive ☐ if negative Vaccination #1 _____ #2 _____
(Date) (Date) (Date)

Titer Result Read By: _____ **Title:** _____

If negative **#1 Given By:** _____ **Title:** _____

#2 Given By: _____ **Title:** _____

Hepatitis B Series: A completed series of 3 doses. Student needs to be advised when to return for the second and third dose. The student is to submit official documentation (i.e. RX pad; dr. office letterhead; lab report) to Nursing Program Office. If student has had the immunization but does not have their records a titer is acceptable.

The minimum interval between the 1st and 2nd dose is 4 weeks. The minimum interval between the 2nd and 3rd dose is 8 weeks, and a total of 16 weeks between the 1st & 3rd doses. Student must have completed the series before orientation for their 2nd academic year.

Titer is only needed if student has had complete series of vaccines but, cannot provide documentation of them all.

#1 _____ #2 _____ #3 _____ or Titer _____ result _____ ☐ positive ☐ negative
(Date) (Date) (Date) (Date)

#1 Given or Titer Read By: _____ **Title:** _____

#2 Given By: _____ **Title:** _____

#3 Given By: _____ **Title:** _____

Tetanus Diphtheria: A tetanus-diphtheria booster is required within 10 years of entrance into the nursing program, and must remain current throughout the program. The tetanus-diphtheria-acellular pertussis (Tdap) is preferred.

Tetanus - diphtheria (Tdap / Td) _____ (Must remain within 10 years, throughout Nursing program)
(Circle one) (Date)

Given By: _____ **Title:** _____

Attending Physician Printed Name: _____

Attending Physician Signature: _____

Facility Name: _____

Address: _____

Phone#: _____ **Fax #:** _____ **Email:** _____

Student Name: _____ EMPL ID: _____

Tuberculosis Skin Test (TST) previously called a (PPD): A TST or QuantiFERON TB gold test is required. If the student does not have and submit documentation of a previous 2 step TST (PPD) to the Nursing Program office; then the student must receive a 2 step TST. The first is administered and read 48 – 72 hours later.

The health care provider must document the following: the location of the injection, who administered it, the date it was administered, the results in mm of induration when read 48 – 72 hours later, positive or negative, who read, and the date read. There is to be a minimum of 7 days and a maximum of 45 days between the two injections.

A Chest x-ray is required for any student who has experienced a positive reaction and is also acceptable if there are other extenuating circumstances, such as allergies to vaccinations causing antibodies to be present that could give a false positive result.

Step 1: TST RF_____LF_____ Given by: _____ **Title:** _____ Date: _____
(Printed Name)

Result:_____**mm** ☐ positive ☐ negative Read by _____ **Title:** _____ Date: _____
(Printed Name)

Signature: _____ **Phone#:**_____

Step 2: TST RF_____LF_____ Given by: _____ **Title:** _____ Date: _____
(Printed Name)

Result:_____**mm** ☐ positive ☐ negative Read by _____ **Title:** _____ Date: _____
(Printed Name)

QuantiFERON TB gold result if tested : _____

Signature: _____ **Phone#:**_____

Attending Physician Printed Name: _____

Attending Physician Signature: _____

Facility Name: _____

Address:_____

Phone#:_____ **Fax #:** _____ **Email:**_____

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Immunization/Skin Test: ***Follow-up Instructions for the Student***

- The Hepatitis B Series and the 2-Step TST require follow-up visits to the Health care Provider. You must be sure to complete them as instructed above.
- It is your responsibility to complete them as outlined above and submit the appropriate documentation to Castlebranch. Failure to do so will prevent you from attending clinical.
- *This completed form is due back when you come for orientation, without this information you will not be allowed to attend clinical.*
- It is your responsibility to make & keep a copy of all records. You will need some or all of this info when you get a job.

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