

CHECK-OFF LIST

NAME: _____

- Use this as the cover sheet to be submitted with your materials.
- Do NOT SUBMIT these items INDIVIDUALLY.
- You will NOT be able to attend the clinical portion of the class without this completed packet.

The following items must be submitted to the Academic Department Assistant, Charlene McClure (NO Building, 744-1150, ext. 2580) by December 7, 2009. Note: *There is a "drop-slot" in the office door (NO-1) for your convenience.*

- Medical Clearance Forms: This includes: Health History, Physical Examination, Supplemental Medical Guidelines, and Immunization Form. **PLEASE NOTE:** It is imperative that all medical forms (immunizations, titers, etc.) be completed as specified. If your Health Care Provider suggests alternate ways of meeting the specified requirements, please contact the Nursing Department to have the suggestions approved. Our requirements are mandated by our clinical agencies and we **must** adhere to their strict guidelines.
 - Copy of your *American Heart Association approved* **CPR (Cardio-Pulmonary Resuscitation) Certification for Health Care Provider.** (copy of front and back, **with signature**, required)
 - 2 informal snapshot-size **Photographs** to be placed on your "Informational Card" and Student Folder.
 - Initiate Background check. (prior to December 7, 2009) American DataBank will email the Nursing Education Department when you have completed this online application. After this confirmation has been emailed to our office, you will stop by (hopefully when you drop off your packet) and pick up the chain of custody form required to have the drug screen test. Your drug screen test should be completed no later than December 14, 2009.
- Check for completeness. Be certain you have documented immunity or the required vaccines.
 - Follow guidelines for TB clearance.
 - Must have minimum of 1st Hep B Vaccine documented.
 - Note: Medical clearance criteria are set to meet clinical agency requirements.

**Palomar College
Nursing Education Department
Instructions for Medical Forms**

Medical Record Form:

Complete the first section prior to your physical examination.

A licensed physician, physician assistant or nurse practitioner must complete the second section.

You may have your physical completed by the doctor of your choice, at a clinic, or at Palomar College Health Services.

Immunization Form:

This form must be completed, current and verified by a physician, physician assistant, nurse practitioner or nurse. It is **imperative** that all forms be completed as specified. If your Health Care Provider suggests alternate ways of meeting the specified requirements, please contact the Nursing Department to have the suggestions approved. Our requirements are mandated by our clinical agencies and we **must** adhere to their strict guidelines.

CPR Certification:

Current CPR (for Health Care Provider) is required of ALL nursing students. The CPR certification must be from an *American Heart Association approved program*. The following agency and school offer CPR training and certification workshops. Please call them for their current schedules.

Palomar College – Emergency Medical Education: (760) 744-1150, ext. 8150

American CPR & First Aid Training – (760) 434-7756

COMPLETED FORMS:

Return all forms to: Palomar College
Nursing Education Department
1140 W. Mission Road
San Marcos, CA 92069

A "Drop Slot" is available in the N.O. Building for after-hours. Reminder: you will need to pick up your drug screen form in the N.O. Building after we have been advised by American DataBank that your online application has been completed.

You will **NOT** be allowed to enter the clinical lab portion of the program without these clearances. Failure to do so may cause you to be dismissed from the program for not complying with the program requirements.

Palomar College
Nursing Education Department
MEDICAL EXAMINATION FORM

TO THE PHYSICIAN: Palomar College requires a physical examination from students enrolling in the Nursing Program. A frank statement of your knowledge of this student's health (mental and physical) will be greatly appreciated. This report goes directly to the Nursing Education Department and will be released only to authorized college and clinical facilities and hospital personnel.

STUDENT'S NAME _____
 (PRINT) Last First Initial

DISCLOSURE AND CERTIFICATION STATEMENTS

I hereby grant permission for the release/disclosure of health screening medical information between and among authorized college, clinical facilities and hospital personnel.

 Applicant's Signature

 Date

Health History – to be completed by student.	CIRCLE "YES" or "NO"	
1. Have you ever been hospitalized?	Yes	No
a. List health problem:	Date:	
b. List operations performed:	Date(s):	
2. Are you under a physician's care now?	Yes	No
a. List name of personal M.D.:		
b. List health problems:		
c. Are you taking medications on a regular basis?	Yes	No
List:		
3. Do you have any allergies?	Yes	No
List medications you are allergic to:		
List other allergies: (food, pollen, contact, animal, dust):		
4. a. Have you had a back or neck or wrist injury?	Yes	No
b. Have you had an injury to any muscle, bone, ligament or tendon?	Yes	No
c. Was medical attention or surgery required?	Yes	No
Please explain:		
5. Do you smoke? Packs per day =	Yes	No
PLEASE INDICATE IF YOU OR A FAMILY MEMBER HAVE HAD:	SELF	FAMILY MEMBER
a. Hypertension (High blood pressure)		
b. Heart disease		
c. Diabetes		
d. Cancer		
e. Tuberculosis		
f. Seizure disorder		
g. Asthma		
h. Chickenpox		
i. Drug and/or alcohol abuse		

**Palomar College
Nursing Education Department
Physical Examination Form**

To be completed by the PHYSICIAN:

BP _____ P _____ R _____ Ht. _____ Wt. _____

	Normal	Abnormal		
Vision:	_____	_____	R.Eye 20/ Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No	L.Eye 20/ C/Lens <input type="checkbox"/> Yes <input type="checkbox"/> No

Hearing:	_____	_____	R. Ear 500 hz _____ dcb 1000hz _____ dcb 2000hz _____ dcb	L. Ear _____ dcb _____ dcb _____ dcb
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PHYSICAL EXAM:

	Normal	Abnormal	Description:
1. Gen Appearance	_____	_____	_____
2. Skin	_____	_____	_____
3. Nodes	_____	_____	_____
4. Skull	_____	_____	_____
5. Ears	_____	_____	_____
6. Eyes	_____	_____	_____
7. Nose	_____	_____	_____
8. Oropharynx	_____	_____	_____
9. Dental	_____	_____	_____
10. Neck & Thyroid	_____	_____	_____
11. Chest	_____	_____	_____
12. Cardiovascular	_____	_____	_____
13. Abdomen	_____	_____	_____
14. Hernia Check	_____	_____	_____
15. Genitalia	_____	_____	_____
16. Anorectal	_____	_____	_____
17. Musculoskeletal	_____	_____	_____
a. Neck	_____	_____	_____
b. Back	_____	_____	_____
c. Shoulders	_____	_____	_____
d. Knee	_____	_____	_____
e. Ankle	_____	_____	_____
f. Feet	_____	_____	_____
g. Other	_____	_____	_____
Neurological	_____	_____	_____

Comments:

Palomar College
Nursing Education Department
Supplemental Medical Guidelines

Nursing students must be able to do total patient care in all nursing areas without physical, emotional or psychological limitations. Written documentation of complete recovery from any previous injury and/or illness must be provided. Following is a brief description of the type of physical activities that students will perform while working with patients in the hospital.

1. Moderate to heavy lifting and carrying (20-40 pounds).
2. Pushing, pulling, bending and kneeling around patients using various types of hospital equipment such as wheelchairs, gurneys, lifting devices and specialized beds.
3. Fine motor dexterity using both hands while preparing medications and manipulating a variety of instruments and assessment devices.
4. Rapid mental processing and simultaneous motor coordination.
5. Extensive periods of walking and standing.
6. Visual discrimination including depth perception and color vision.
7. Ability to hear the spoken word in settings where other sounds are present.
8. Working with hands in water (frequent handwashing is required).
9. Working with various materials and substances to which some individuals may be allergic.
10. Casts, splints, braces are not allowed in clinical settings.

Mark the appropriate box below:

After reviewing the "Supplemental Medical Guidelines" listed above and based on findings from the patient's history and physical exam, I certify that the above student is physically and mentally capable of fully participating in a Palomar College's Nursing Program.

The following health problems(s) should be further evaluated **PRIOR** to participation in a clinical assignment:

Examiner's Signature

Date

License # _____

Staple Business Card Here

PALOMAR COLLEGE NURSING EDUCATION DEPARTMENT IMMUNIZATION FORM

Student's Name: _____

1. TUBERCULIN TEST (PPD) REQUIRED ANNUALLY
NOTE: Some vaccines can interfere with the 2-Step PPD. If a 2-Step PPD is required (2 PPD skin tests at least 1 week apart), complete the 2-Step before having any other vaccinations.

A. Dates of two (2) documented negative PPDs:

#1. PPD Date Read: _____ Result: negative ___ positive ___

#2. PPD Date Read: _____ Result: negative ___ positive ___

- a. Two negative PPDs are required - current year and year prior (without expiring between).
- b. If your last documented negative skin test was within one year, and a PPD was not done the year prior or has expired, a second, **single PPD** test will be needed.
- c. If more than one year has elapsed since your last documented negative skin test, the **2-step Procedure (2 PPD skin tests at least 1 week apart)** is required. **(Please complete this before receiving any other vaccinations.)**

or B. A one-step BAMT (Blood assay for Mycobacterium tuberculosis) or Quantiferon TB Gold.

Date Verified Negative: _____

or C. History of Positive Skin Test: (both a. and b.)

a. Date of negative chest x-ray (within 6 months of starting the Nursing Program) _____.

b. A copy of the negative chest x-ray results must be submitted with this form.

(A symptom report signed by your doctor will be required annually instead of the annual PPD test.)

2. MEASLES, MUMPS, and RUBELLA (MMR) VACCINE or POSITIVE TITER REQUIRED

A. Two (2) MMR vaccines: Date given #1: _____ Date given #2: _____

or B. Date of Positive Serum Titers: Measles _____ Mumps _____ Rubella _____

(Reminder: If not immune vaccine should be given)

3. HEPATITIS B (May begin program with one vaccine and present proof of second and third dose when received.)

A. Hepatitis B Vaccinations:

Date given #1: _____ Date given #2: _____ Date given #3: _____

or B. Date of Positive Titer _____ (Reminder: If not immune vaccine should be given)

4. VARICELLA (Chicken Pox) 2 doses of VACCINE or POSITIVE TITER REQUIRED

A. Two (2) Varicella Vaccinations: Date given #1: _____ Date given #2: _____

or B. Date of Positive Titer _____ (Reminder: If not immune vaccine should be given)

5. Tetanus, Diphtheria, Pertussis (Td/Tdap) – Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yr

Tdap date given: _____ Td booster date given: _____

6. FORM COMPLETED BY:

License # _____ Date: _____

Name & Title

NOTE: These requirements are mandated by our clinical agencies and we must adhere to their strict guidelines. Please contact the Nursing Department if you have questions regarding these requirements.