7704 Leesburg Pike, Suite 1000 Falls Church VA 22043
Telephone: (703) 891-1787 Fax: (703)891-1789
www.standardcollege.edu

HEALTH HISTORY AND PHYSICAL FOR NURSING PROGRAM

This form must be filled out by applicant and a licensed primary care provider: physician, physician's assistant, nurse practitioner. Physical examinations must be completed no sooner than 3 months prior to entering the program.

PART I Personal Information to be completed by the STUDENT- PLEASE PRINT.

Last Name:	First Name:	Date Of Birth:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	E-Mail:

To the best of my knowledge, I do not have a physical or mental condition that would prevent me from performing the essential requirements of the applicable Practical Nursing Program. I hereby authorize the release of my medical information to clinical affiliates after my admission and prior to being assigned to a clinical rotation. I understand that I may be dismissed from the program if I knowingly submit false information.

Student Signature: _____ Date: _____

PART II Physical assessment — to be completed by a HEALTHCARE PROVIDER

Height(in):	Weight (lbs):
B/P:	T:
HGB (or HCT):	Urinalysis:
Sugar: Alb:	Micro:
Vision: OD:	OS:
Corrected? Yes No	
General Appearance:	

ANY IRREGULARITIES OF THE FOLLOWING?

	YES	NO		YES	NO
Head			Cardiovascular system		
Ears			Abdomen		
Nose:			GI system		
Throat			GU system		
Neck			CNS/Reflexes		
Breasts			Back		
Chest			Extremities		
Please Explain any YES answers:					

Describe any conditions currently being treated: _____
Allergies: _____
Has the student ever been under observation for any severe physical or emotional disease or drug problem?
IF so, EXPLAIN: _____

PART III Essential Functions for Students - to be completed by a HEALTHCARE PROVIDER

Students entering the program must be able to perform all of the following essential functions and standards to become a licensed nurse.

Yes	No	
		1. Communication: Establish interpersonal rapport and communicate in English, both verbally and in writing with clients, physicians, peers, family members and the health care team from a variety of social, emotional, cultural and intellectual backgrounds.
		2. Mobility: Physical abilities sufficient to move from room to room and maneuver in small spaces and administer cardio-pulmonary procedures.
		3. Motor Skills: Gross and fine motor abilities sufficient to provide safe and effective nursing care in order to calibrate and use equipment; position patients/clients.
		4. Hearing; Auditory ability sufficient to monitor and assess health needs in order to hear monitor alarms, emergency signals, ausculatory sounds, and cries for help.
		5. Visual: Visual ability sufficient for observation and assessment necessary in nursing care in order to observe patient/client responses.
		6. Tactile: Tactile (touch) ability sufficient for physical assessment and/or those functions related to therapeutic interventions.

Are there any other essential functions that you believe the program applicant may lack that would interfere with their ability to become a licensed nurse? Yes_____ No_____

Student Name: _____ **DOB:** _____

PART IV Required Immunizations — to be completed by a HEALTHCARE PROVIDER

The following immunizations are required. It is the student's responsibility to see that the completed form is submitted to Standard College prior to clinical assignment. All immunizations must be documented by a shot record unless immunization is given the day of the physical exam. Express results in numerical values. Attach copies of titer results.

Hepatitis B	• Dates of three (3) doses of Hepatitis B Recombinant Vaccine OR • Serum Titer laboratory test result indicating immunity • If vaccine declined, must be offered annually and must have declination statement signed and on-file annually	Date of injection: _____/_____/_____ (1) Date of injection: _____/_____/_____ (2) Date of injection: _____/_____/_____ (3) Positive Hepatitis B titer: Date: _____/_____/_____ ****OR Copy of titer indicating positive immunity must accompany this form**
Influenza	• Influenza (inactivated virus) Vaccine (Annual single dose required or mask during flu season)	Date of injection: _____/_____/_____
Rubella Rubeola Mumps	• Measles / Mumps I Rubella Vaccine (MMR) - live virus (Required; contraindicated if pregnant) • 2 doses required at least 1 month apart. First dose must be given on or after one year of age; and after 1971 for combined MMR vaccine or after 1967 for individual doses. • The student must have proof of MMR vaccination or documented proof of immunity shown by mumps, rubeola, and rubella titers.	Measles, Mumps, Rubella (MMR): Date of injection: _____/_____/_____ (1) Date of injection: _____/_____/_____ (2) Documented immunity of: ____ Mumps titer: Date: _____/_____/_____ ____ Rubeola titer: Date: _____/_____/_____ ____ Rubella titer: Date: _____/_____/_____ ****OR copy of titer indicating positive immunity must accompany this form.**
Pertussis	• Tdap Vaccine (Recommended; contraindicated if pregnant) • Tdap is a one-time single dose booster • Adults need a Td (tetanus/diphtheria) booster every 10 years.	Date of injection: _____/_____/_____ Please indicate type: _____Td ____Tdap
Varicella	• Varicella - zoster Vaccine (live virus) (Recommended; contraindicated if pregnant) • Dates of two (2) doses, 4-8 weeks apart OR • Serum Titer laboratory test result indicating immunity	Date of injection: _____/_____/_____ Date of injection: _____/_____/_____ ____ Varicella titer: Date: _____/_____/_____ ____ Immune ____ Not immune
Tuberculosis	Initial Screen: (REQUIRED) • 2-step Tuberculin Skin Test (1ST) - Two (2) TSTs placed and read (in MM induration) at an interval 2 weeks apart • If the individual provided documentation of a TST placed and read within the past 12 months, that test may be used as the lst step of the 2-step test process. • TB symptom screen questionnaire	Tuberculin Skin Test: • Date of injection: _____/_____/_____ Date read: _____/_____/_____ Results: _____ • Date of injection: _____/_____/_____ Date read: _____/_____/_____ Results:_____ ****Please Record actual mm of induration, transverse diameter; if no induration, write "0".**
	Persons with previous history of positive TB test: • Initial Chest X-ray (CXR) • CXR must be current within the past year – negative • A TB symptoms screen completed initially and yearly thereafter. • Chest X-ray if symptomatic.	Chest X-Ray Date read:_____/_____/_____ Results:_____ ****A copy of the x-ray report on official letterhead must be attached.**
	• Annual Screen: (REQUIRED) • (1) TST documented placed and read • TB symptom screening questionnaire • Chest x-ray for positive TST (only for new conversion) • If the TST conversion occurred within the past (2) years and the individual was not treated with ant.-tuberculosis medications, complete a TB screening questionnaire every (6) months for (2) years	Treatment for TB or LTBI Date treatment started:_____/_____/_____ Date treatment completed:_____/_____/_____ Name of medication:_____ ****Documentation of treatment must accompany this form.**

HEALTH CARE PROVIDER INFORMATION AND SIGNATURE: (must have all information)

Printed Name and Title: _____ **Name of Practice or Clinic:** _____

Address: _____

Office Phone Number: _____ **Official Stamp (if available):**

Health Professional's Signature:_____ **Date:** _____