Nursing
Virginia Highlands Community College

Student Information, Physical Assessment and Immunization Record Form

Directions for the form:

- **Student Information** on page 1 is to be filled out completely by the student.
- **Physical Assessment** on page 2 is to be completed by a medical doctor, physician's assistant, or nurse practitioner.
- **Immunization Record** on page 3 is to be filled out by health care provider, signed and dated. Proof of immunization, such as health department record or lab result must be attached. Do not leave any item blank. It is the student's responsibility to make sure that the form and documentation are complete.

Deadlines: LPN to RN Bridge students should submit to CastleBranch by June 1. New students entering the fall semester should submit to CastleBranch by August 1.

Student Information

EMPL ID:_____Birth Date (MM/DD/YYYY):_____Academic year:_____

Last Name:_____First Name:_____MI:_____

Address:_____

City:_____State:_____Zip Code:_____

Student email:_____

Home Phone:_____Cell Phone: _____

In Case of Emergency

Name:_____Relationship:_____

Address:_____City:_____State:_____

Zip:_____Home Phone:_____Cell Phone:_____

In case of emergency, I give Virginia Highlands Community College Nursing permission to obtain medical assistance and to notify my emergency contact person(s). Initial answer below.

_____Yes _____No

I understand that my medical information may be released to clinical agencies as required by agency contracts. Initial answer below.

_____Yes _____No

BY MY SIGNATURE, I AUTHORIZE VIRGINIA HIGHLANDS COMMUNITY COLLEGE NURSING TO RELEASE THE INFORMATION ON THIS FORM TO THE AGENCIES WHERE I HAVE CLINICAL LABORATORIES AS REQUIRED BY AGENCY CONTRACTS.

SIGNATURE:_____ Date: _____

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Student Name:_____

Physical Assessment (to be completed by the physician, physician's assistant or nurse practitioner).

Please check in the YES or NO column to indicate status.

Height_____**Weight**_____**Blood Pressure**_____**Pulse**_____**Temp**_____**Vision**_____

Any abnormalities of the following areas?	**Yes**	**No**	**If yes, PLEASE EXPLAIN (include current treatments and medications)**
Head, Ears, Nose or Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neurological			
Psychiatric			
Skin			
Lymph Nodes			

Physical and Mental Status	**Yes**	**No**	**If yes, PLEASE EXPLAIN (include current treatments and medications)**
Is there loss or impaired function of any organ or limb?			
Is there any impairment or lifting restrictions? (Need to be able to individually lift and carry 50 pounds, occasionally lift 51-74 pounds, pushing and pulling up to 200 lbs. with assistance, occasional lifting up to 200 lbs. with assistance).			
Are there any recommendations for any physical or emotional/psychological restrictions?			
Is there any reason the individual cannot physically, emotionally, or psychologically participate in a health care setting as a health care provider?			

Health Care Provider's signature:_____Date:_____

Print Name and Title: _____

Address:_____Phone:_____

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Student Name:_____

To the clinician: **Please indicate date of immunization, disease, lab tests (titers) and initial in "Initials" column. Comments may be written in the NOTES column or under Additional Comments at the bottom of this page.**

TEST	1st TB Test	2nd TB Test	INITIALS	NOTES
TB-Step 1 **Mantoux-**if positive submit lab report of chest x-ray and physician documentation. If positive do not proceed to Step 2 Test. **TB-Step 2** Retest in 1 to 3 weeks after first TST result is read.	Test Date: Date PPD read: Results in mm:	Test Date: Date PPD read: Results in mm:		**Mantoux Tuberculin Skin Test-**test must be current. A negative chest x-ray and yearly physician documentation of negative physical signs and symptoms of tuberculosis is required for any positive TB skin test.

VACCINE	DOSE #	DATE	INITIALS	NOTES
MMR (Measles, Mumps, Rubella)	**1**			**MMR-**evidence of two MMR immunizations after the first birthday **OR** documentation of 2 measles shots and 2 mumps shots and one rubella shot **OR** lab report with positive titer showing proof of immunity for measles (rubeola), mumps and rubella.
	2			
OR				
Individual Shots: Measles	**1**			
	2			
Mumps	**1**			
	2			
Rubella	**1**			
OR				
Attach documentation of titers:				
Measles(Rubeola)	**Titer**			
Mumps	**Titer**			
Rubella	**Titer**			
Hepatitis B	**1**			**Hepatitis B**-evidence of three shot series **OR** 2 shot series (Heplisav-**B** (Dynavax) (**OR** lab report of titer showing proof of immunity.
	2			
	3			
	Titer			
Varicella (Chicken Pox)	**1**			**Varicella**-evidence of 2-shot immunization series **OR** lab report of positive titer showing
	2			

	Titer			proof of immunity.
COVID Vaccination (Circle Brand): Pfizer-BioNTech Moderna Johnson & Johnson Janssen	**1st Dose Date:**	**2nd Dose Date:**	**Booster Date:**	Comments
Fit Testing Student medically cleared to be fit tested	**Yes**	**No**		
Tdap (Tetanus-Diphtheria-Pertussis)	**Tdap**			**Tdap (Tetanus-Diphtheria-Pertussis)-** Vaccination must be within the last ten years.
Clinician Signature:			**Date**	**Address**
Print Name			**Title**	**Phone**

Additional Comments: