**SOUTH PLAINS COLLEGE**

**NURSING DEPARTMENT-LEVELLAND**

**ASSOCIATE DEGREE NURSING PROGRAM**

**IMMUNIZATION REQUIREMENTS AND PHYSICAL FORM**

NAME ADDRESS

 (City, State, Zip)

PHONE NUMBER STUDENT ID #

AGE SEX DATE OF BIRTH WT. HT.

PHYSCIAN DATE OF VISIT

**Please have your physician or health clinic complete the following data.**  Our program follows the requirements of the area hospitals where student clinical rotation is completed. **Please bring a printed list of all current medication(s) prescribed by your physician.**

**I. IMMUNIZATIONS:**

1. **MMR VACCINE:** If you were born after 1957, you must show proof of two vaccines, or lab titer, by physician’s dated statement and immunization record. If your lab titer or vaccine was before 1980, you must have it repeated because of a major change in the vaccine that year.

Date: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Titer Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immune: Yes □ No □

1. **VARICELLA must have documented proof of disease or vaccine.**

Have you ever had Chicken Pox? Yes □ No □

Have you ever been vaccinated for Chicken Pox? Yes □ No □

If the answer is no to both questions, a Varicella titer is required. If the titer is negative, two (2) vaccines are required.

Titer: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immune: Yes □ No □

Vaccine: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **HEPATITIS B** in a series of 2 dose (Heplisav-B) or 3 dose (Energix-B or Recombivax HB) is required.

Date: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

1. **TDAP Vaccine** (Must be within last 10 years) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Meningococcal Vaccine (MCV4):** Required if under 22 years of age Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **TB Test (MANTOUX PPD)**  must be within last 12 months:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF POSITIVE: X-RAY** Date: \_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(Additional x-rays every two years are no longer required. Refer for follow-up & treatment if becomes Symptomatic).***

1. **Flu Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ H. COVID-19 Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ Booster\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please provide a copy of all vaccinations in addition to the documentation above**

**II. EXAM DATA**

Blood pressure: Pulse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Respirations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Range Of Motion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Squats: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Physical Condition:

In your opinion, is this individual in suitable physical and emotional condition to attend the Associate Degree Nursing Program?

If not, why?

 Signature of Examining Physician Physician's Name (please print)

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| **III. PHYSICAL HISTORY:**  (to be completed by applicant) |
|  |  |  |
| A. Communicable Disease History: Circle answer |
|  |  |  |
|  Have you had? | Have you received? | Sexually transmitted diseases? |
|  Chickenpox yes no | Rubella vaccine yes no | Syphilis yes no |
|  Measles/Rubeola yes no | Measles vaccine yes no | Gonorrhea yes no |
|  Rubella yes no | Polio vaccine yes no | Other yes no |
|  Scarlet Fever yes no | Mumps vaccine yes no |  If yes, when and how treated |
|  Hepatitis yes no | Hepatitis B vaccine yes no |   |
|  What type?  COVID-19………….… yes no  |  When? COVID-19 vaccine……...yes no |  |
|  |  |  |
|  Tuberculosis (TB) History: |
|  Have you lived outside the United States? Where? yes no |
|  Family member ever have TB or been treated for TB? yes no |
|  Have you ever been treated for TB? yes no |
|  Have you ever had a POSITIVE TB skin test? yes no |
|  If yes, last chest x-ray?  |
|  Have you ever had the BCG vaccine? yes no |
|  |
| B. Accidents/Illness On-The-Job: |
|  Have you ever had an accident, injury, or illness, which caused you to lose time from work? ………………. yes no  If yes, give date and explain.  |
|  Have you received or been receiving COMPENSATION as a result of injury or illness? yes no |
|  Did you receive a settlement for the injury or illness? yes no |
|  Do you have any physical limitations or disabilities? yes no |
|  |
| C. Surgeries: |
|  Did you ever have an operation? yes no |
|  Please list  |
|  |
| D. Allergies: |
|  Have you ever had hives or other allergic reaction to foods or drugs? yes no |
|  Please list  |
|  |
| E. Exposures |
|  Have you ever had a SIGNIFICANT exposure to: |
|  High level noises yes no | Formaldehyde yes no |
|  Asbestos yes no | Ethylene Oxide yes no |
|  Chemotherapy drugs yes no | Blood & body Fluids yes no |
|  Comments: | Needle Puncture wound yes no |
|   |
|  |  |
| F. Personal History: |
|  Medication now taking  |
|  Do any of these medications affect your skills? yes no |
|  Have drugs/alcohol ever been a part of your lifestyle? yes no |
|  Have you ever been treated for drug or alcohol dependency? yes no |
|  If yes, when and how treated?  |
|  Have you ever had any fractures, serious injury or been knocked unconscious? yes no |
|  If so, please describe  |
|  Have you ever been rejected for life insurance, military service, employment, or disability insurance? yes no List  |

|  |
| --- |
| Are you subject to any limitations in terms of activity or work? yes no |
| List  |
|  |  |
| G. Past Medical History: | L. General: |
|  Have you ever had? |  Are you frequently ill? yes no |
|  Anemia yes no |  Do you get spells of exhaustion? yes no |
|  Diabetes yes no |  Do you have periodic fever, chills,  |
|  Epilepsy-seizures yes no |  or night sweats? yes no |
|  Kidney disease yes no |  Are you considered a nervous person? yes no |
|  Immune system disorder yes no |  Have you ever had a problem with  |
|  Nervous breakdown yes no |  depression? yes no |
|  Pneumonia yes no |  Have you ever attempted suicide? yes no |
|  Rheumatic fever yes no |  Did you ever have a tumor, growth,  |
|  Stroke yes no |  or cancer? yes no |
|  Arthritis yes no |  Have you ever had or now have: |
|  Heart Attack yes no |  Blood clots? yes no |
|  Cancer yes no |  Blood vessel disorder? yes no |
|  Lymphatic System disorder yes no |  Thrush, yeast, fungus infections? yes no |
|  Blood disorder yes no |  Dental problems? yes no |
|  Varicose veins yes no |  Liver, pancreas problems? yes no |
|  |  |
| H. Family History: | M. Head: |
|  Has anyone related to you ever had? |  Do you have frequent or  |
|  Diabetes? yes no |  severe headaches? yes no |
|  Cancer? yes no |  Have you had fainting spells, |
|  High blood pressure? yes no |  dizziness, or blackouts? yes no |
|  Heart disease? yes no |  |
|  Are your parents living? | N. Eyes: |
|  Father? yes no |  Do you wear glasses? yes no |
|  Mother yes no |  Do you wear contacts? yes no |
|  If no, give cause of death  |  Do you have glaucoma? yes no |
|  Are your parents in good health? yes no |  Has there been a change in your |
|  If no, give problem  |  vision recently? yes no |
|  |  Date of last eye exam  |
| I. Ears: |  Are you color blind? yes no |
|  Are you hard of hearing? yes no |  |
|  Do you have ringing in your ears? yes no | O. Nose and Throat: |
|  Do you have frequent or? |  Do you have frequent sore throats? yes no |
|  chronic ear infections yes no |  Do you have hay fever? yes no |
|  |  Do you have frequent sinus problems? yes no |
| J. Neck: |  Do you have frequent or  |
|  Have you had thyroid trouble? yes no |  chronic hoarseness? yes no |
|  Do you have frequent swollen  |  |
|  glands in the neck? yes no | P. Genitourinary: |
|  |  Have you had kidney stones? yes no |
| K. Dermatologic: |  Have you had frequent kidney infections? ...yes no |
|  Do you have frequent skin rash or itching? yes no |
|  Have you detected any lumps? yes no |  |
|  Have you ever had eczema |  |
|  on hands or face? yes no |  |
|  |  |