Divisions of Allied Health and Nursing

INCOMING STUDENT PHYSICAL EXAMINATION FORM

All incoming Nursing and Allied Health students must return this completed, signed form PRIOR TO your Compliance deadline:

Student's Name: ____ **Valencia ID#**: ____________________

Street Address:____

City: ___________________________________ **State**: ______ **ZIP**: ___________ **Country**: __________________

Date of Birth (mm/dd/yyyy): _____/_____/____________ **Gender**: ___ Male ___ Female

____ **Allied Health Student** (Allied Health Program: ___________________) ____ **School of Nursing**

Do you now have or have you ever had:

	No	Yes		No	Yes		No	Yes
Allergies/Asthma	___	___	Epilepsy/Seizures	___	___	Positive PPD Test/Tuberculosis	___	___
Cancer	___	___	Gastrointestinal Disorder	___	___	Psychiatric/Behavior Disorder	___	___
Cardiovascular Disease	___	___	Hepatitis/Jaundice	___	___	Pulmonary/Lung Disease	___	___
Diabetes	___	___	High Blood Pressure	___	___	Skin Problems/Disease	___	___
Drug/Alcohol Abuse	___	___	Kidney/Urinary Disorder	___	___	Tobacco use (current or past)	___	___
Endocrine Disorder	___	___	Musculoskeletal Disorder	___	___			
Other:________________			Other:________________					

Comments (please explain any YES answers above):

____

____

List all allergies: ____

Surgeries (with dates): ____

____

Previous hospitalizations (with dates):

____

____

Current medications: ____

____

I attest that the information shown above is true and accurate to the best of my knowledge.

Student's Signature:____ **Date:**______________________

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PHYSICAL EXAMINATION

(This page must be completed and signed by your physician, nurse practitioner or physician assistant.)

Patient's Name: ____

Height: ________ **Weight:**________ **BMI:** _____ **Temp:**____ **BP:**_____ **Pulse:**____ **RR:**________

	Normal	Abnormal	Comments
HEENT	_____	_____	____
Neck	_____	_____	____
Lungs	_____	_____	____
Heart	_____	_____	____
Abdomen	_____	_____	____
GU (if indicated)	_____	_____	____
Extremities	_____	_____	____
Neurologic	_____	_____	____
Adenopathy	_____	_____	____
Vascular	_____	_____	____
Skin	_____	_____	____
Psychiatric	_____	_____	____

To your knowledge, does this patient have any significant medical problems? _____Yes _____No
Explain: ____

To your knowledge, does this patient have any emotional, psychological or psychiatric problems? ____Yes _____No
Explain: ____

Do you know of any physical or psychological reason why this student would not be able to withstand the rigors of his/her program of study? _____Yes _____No

Explain: ____

Physician/NP/PA Name: ____ **Phone:** (______) _____________

Address: ____

Physician/NP/PA Signature: ____ **Date**: ______________

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IMMUNIZATIONS

Student Name: ________________________________

TUBERCULOSIS(yearly)

PPD Applied Date: ___________________________ PPD Read: _______________________________

TB Screen/TB symptom sheet(if positive PPD) yearly YES NO

CXR Date: ___________________ CXR Results/Report (if positive PPD) ____________________________

Provider Signature:____Date: ________________________

MEASLES, MUMPS, RUBELLA

Two vaccinations within the last 20 years OR Titers(Rubella and Rubeola) within the last 5 years that show positive.

-A negative or equivocal titer requires a booster.

VACCINE		TITERS		
MMR #1 Date ___________________	**Rubeola**	Positive	Negative	Equivacol
MMR #2 Date ___________________	**Rubella**	Positive	Negative	Equivacol

Vaccine Date(if titer negative or equivocal)__________

Provider Signature:____ Date: __________________________

VARICELLA

Two vaccinations within the last 20 years OR Positive Titers within the last 5 years

-A negative or equivocal titer requires a booster.

VACCINE	TITER			
Varicella #1 Date _____________________	**Varicella**	Positive	Negative	Equivacol
Varicella #2 Date _____________________	**Vaccine Date**(if titer negative or equivocal)__________			

Provider Signature:____ Date: _________________________

TETANUS/DIPTHERIA/PERTUSSIS

One time Tdap required and then Td boosters every 10 years

Tdap date__________________ Td date___________________

Provider Signature:____ Date: ________________________

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Student Name: ___________________________

HEPATITIS B **(Strongly recommended for healthcare workers)(Can decline with a signed waiver)**

Hep B Vaccine #1 date _________________ Waiver date_________________

Hep B Vaccine #2 date _________________ **OR**

Hep B Vaccine #3 date _________________

Provider Signature:____ **Date:** _______________________

INFLUENZA VACCINE

Required yearly when new vaccine is available(typically Sept/Oct)

Flu Vaccine Date____________________ **OR** Waiver Date___________________

Provider Signature:____ **Date:** ______________________

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Tuberculosis Symptom Screening Sheet

Date: ___________________________

Student Name: ____ **VID #:** ___________________________

Please complete the following questionnaire as part of the tuberculosis (TB) screening process.

Do you have, or have you had in the last two months, any of the following:

Symptoms	**Yes**	**No**	**Symptoms**	**Yes**	**No**
Productive Cough	____	____	Fever	____	____
Night Sweats	____	____	Sore Throat	____	____
Shortness of Breath	____	____	Rash	____	____
Loss of Appetite	____	____	Swollen or Tender Lymph Nodes	____	____
Unusual Tiredness	____	____	Open or infected sore or wound	____	____
Unintentional Weight Loss	____	____			

Please answer the following questions:	**Yes**	**No**
Have you ever been exposed to TB? If yes, when?	____	____
If yes, please explain____		
Have you ever had a positive TB skin test?	____	____
If yes, please explain____		
Have you ever take BCG vaccine?	____	____
If yes, please explain____		
Have you ever taken any medication for TB?	____	____
If yes, please explain____		
Are you taking any routine medication?	____	____
If yes, please explain____		

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HEPATITIS B DECLINATION

I understand that, due to my exposure to blood or other potentially infectious materials, I amy be at risk for acquiring the Hepatitis B (HBV) infection. I have been informed of the recommendation that all healthcare workers be vaccinated with the Hepatitis B vaccine. However, I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I could be at risk of acquiring Hepatitis B, a serious disease.

Student's Printed Name: ____

Student's Signature: ____

Date: __________________

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INFLUENZA VACCINE WAIVER

Influenza vaccine is strongly recommended for healthcare workers for their protection and for the protection of patients, their families and to the community. In the U.S., approximately 200,000 people are hospitalized and 36,000 persons die from influenza each year. The annual influenza vaccine is highly effective in PREVENTING infection. Valencia's Allied Health and Nursing Divisions are committed to the health and well-being of students, faculty, and patients and we consider the influenza vaccine a PATIENT SAFETY priority. PLEASE HELP PREVENT THE TRANSMISSION OF INFLUENZA BY RECEIVING THE ANNUAL INFLUENZA VACCINE.

DECLINATION OF INFLUENZA VACCINE: **I have read the above statement regarding seasonal influenza vaccine. I fully understand that my declination of this vaccine will necessitate my wearing a mask during the entire shift in most clinical settings as required by the facility.**

Students Printed Name: ____

Student's Signature: ____

Date: ___________________________

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AHA BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS

All students enrolled in programs in Valencia's Divisions of Nursing or Allied Health are required to obtain and maintain the American Heart Association Basic Life Support (BLS) for Health Care Providers certification. For the purpose of Valencia student clinical rotations, **ONLY** American Heart certification is acceptable per our hospital clinical partners. For students required by their respective program to have advanced certifications (ACLS and/or PALS), only American Heart Associal certification is acceptable.

Students will upload a copy of their current American Heart Association care to their CastleBranch Tracker. You must upload a copy of both the front and back of the card. It is the student's responsibility to maintain all certifications required by the program in which he/she is enrolled and to present documentation of updated certifications during the duration of their enrollment.

CPR Options – BLS Healthcare Provider Classes

Valencia College

Offers certification and recertification on a regular basis on the West Campus. You may view upcoming classes and register online at http://valenciacollege.edu/cehealth . You must have your V number to register to obtain student pricing

- Certification $40.00
- Recertification of an ***unexpired*** AHA BLS card $20.00

For more information or to pay by cash or check contact:
Office of Continuing Education and Clinical Compliance - West Campus – HSB-200
Email: hscompliance@valenciacollege.edu or call 407-582-1793

Other Local Providers of BLS Healthcare Provider Courses

CPR & ACLS Academy of Winter Park (Rick McGarrity)

- www.cprandaclsorlando.com
- For schedule, pricing and/or register for classes call 407-629-5183
- Provider does not accept credit cards/debit cards

All Care Health Services

- www.allcarecpr.com/student
- 407-432-4756
- Present current Valencia ID

On-Call Training Solutions

- www.on-calltrainingsolutions.com
- 407-446-0996

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N 95 RESPIRATOR FIT TESTING

Name:____ **VID#:**_______________________

Program:____________________ **Phone:**_________________ **Email:**________________________

- At the time of your fit testing you cannot be fit tested if you have a fever, nasal contestion, or any other cold or flu like symptoms. Please be fit tested after your symptoms have gone away.
- Do NOT eat, drink, smoke or chew gum for at least 15 minutes before your fit testing.
- You must be clean shaven so that the respirator will form a good seal. You must remain clean shaven as long as your job requires you to ear a respirator. Your fit test cannot be conducted if you are not clean shaven.
- If you wear glasses, please remember to bring them with you to the fit test.
- Any change in your weight greater than 10 pounds or change in your facial shape (such as dental procedures or facial surgery) or scarring will require you to be fit tested to insure you still wear the same respirator.
- If a strap breaks or the respirator is knowed off leave the room and replace or refit the respirator.
- If you are wheezing, short of breath, or have an upper respiratory illness you cannot wear a respirator until the symptoms are gone.

Student Signature:____ **Date**:______________________

To Be Completed by the Fit Tester

Sensitivity Test

_____ Saccharin # squeezes _____ 5 _____ 10 _____ 20 _____pass _____fail _____ na

_____ Bitrex # squeezes _____ 5 _____ 10 _____ 20 _____pass _____fail _____ na

Fit Check

_____ Positive Pressure Fit Check Test (normal breathing causes ample movement) ____pass ____fail

Fit Test

_____ Satisfactory fit test performed (indicate respirator manufacturer and size below)

_____ Could not complete fit testing process

_____ Could not fit student to any available respirators (**Contact hscompliance@valenciacollege.edu**)

Comments:

Respirator (please check the respirator manufacturer and size)

_____ Kimberly Clark (KC) Technol _____Small _____Regular

_____ 3M N95 _____Small _____Regular

____ ______________________

Certified Fit Tester Date

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