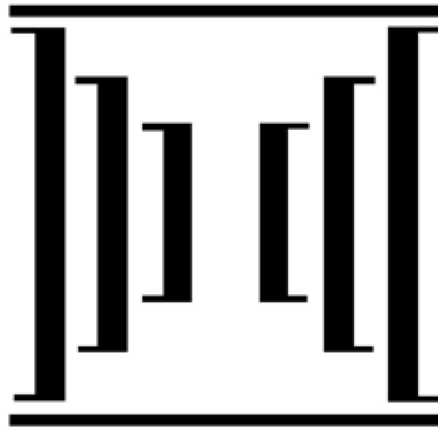
NAME: ____

SEM/YEAR: ____________________________________

EMAIL: _______________________________________



Student Medical Form for North Carolina Community College System Institutions

Associate Degree Nursing Program

**Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.*

APPLICANT MEDICAL FORM CHECKLIST **{CLINICAL REQUIREMENTS}**
Acceptable completed forms MUST be in the student file.

1. Immunization Page is considered complete when filled in, required documents are attached, and signed by the healthcare provider.

2. Physical Examination {page 6} must be completed. Statement of applicant's physical and mental/emotional health must be completed, dated, and signed by physician, PA, FNP, or have an agency stamp

IMPORTANT – The immunization requirements must be met. Acceptable Records of Your Immunizations May Be Obtained from Any of the Following {Be certain that your name, date of birth, and ID Number appear on the document. The records must be in black ink and the dates of vaccine administration must include, day, and year**. Keep a copy of your records**.}

- High School Records – These may contain some, but not all your immunization information
- Personal Shot Records – must be verified by a doctor's stamp or signature or by a clinic or health department stamp
- Local Health Department
- Military Records
- Previous College or University – Your records do not transfer automatically. You must request a copy
- Health Care Facilities where you may be employed

COVID-19 Vaccination	Must indicate one dose or two doses as well as the manufacturer
Current Tetanus Booster and Tdap	1 dose Tdap, then Td Booster every 10 years {must indicate if Booster}
Hepatitis B or Hepatitis A/B Combination	2 or 3 doses depending on vaccine
MMR (Measles, Mumps, Rubella)	2 doses or positive titers (Results include ref range)
Varicella	2 doses or positive titers (Results include ref range)
Influenza	1 dose annually (before OCT 15)
PPD	Two-step (two tests within a 1-3 week period or 21 days)

Applicants should adhere to vaccine schedule for initial vaccines and updates as required by clinical agencies.

Students will not be allowed to attend clinical until immunizations are complete.

Initialing this page indicates you have read and understand the clinical requirements.

____

Revised: 2015, 2019, 2021, 2022

PERSONNAL & INSURANCE INFORMATION	***(Please print in black ink)***	***Completed by applicant***	
Last Name	First Name	Middle/Maiden Name	Social Security Number

Permanent Address	City & State	Zip Code

Phone Number	Date of Birth	Gender	Previously Enrolled	If yes, Dates

Hospital/Health Insurance (Name & Address of Company)	Company Telephone #

Name of Policy Holder	Social Security #	Employer

Policy/Certificate Number	Group Number	Is this an HMO/PPO/Managed Care Plan

Emergency Contact Person	Relationship	Phone Number

Address	City	State	Zip Code

CURRENT MEDICAL CONDITIONS	***(Please print in black ink)***	***Completed by applicant***

Revised: 2015, 2019, 2021, 2022

CURRENT MEDICATIONS	***Use***	***Dosage***

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

ALLERGIC REACTIONS	***Yes***	***No***	***EXPLANATION***
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Ibuprofen			
Codeine			
Other drugs, medicines, chemicals (specify)			

Revised: 2015, 2019, 2021, 2022

IMPORTANT INFORMATION...PLEASE READ AND COMPLETE

STATEMENT BY APPLICANT (OR PARENT /GUARDIAN, IF APPLICANT UNDER AGE 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. **(Not applicable to community colleges.)**

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. **(Not applicable to community colleges.)**

____ ____________________

Signature of Student **Date**

____ ____________________

Signature of Parent/Guardian if student under age 18 **Date**

Eastern CCEP Credentialing Checklist

The elements as specified on the *Eastern CCEP Clinical Passport* document serve as the minimum requirements for student participation in the clinical setting of the participating agencies. The list represents the highest standards as evaluated by the Eastern CCEP Committee. Note that clinical agency contracts may specify additional requirements based on the areas in which students may be placed or regulations established by that agency or health system.

Official documentation of all requirements must be kept by the school program or by the vendor contracted for electronic documentation.

Adopted 03/17; Rev. 10/25/17, 1/22/19, 1/27/2021

Incomplete health forms and immunization records will be subject to immediate disqualification from the admissions process.

Medical issues that will hinder vaccinations requires a doctor's note (must be on letterhead) indicating issue and results if received/receiving vaccination.

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** Must repeat measles vaccine if received even one day prior to 12 months of age

*** Only laboratory proof if immunity to measles, mumps, rubella, and varicella is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

Revised: 2015, 2019, 2021, 2022

VACCINATIONS	**(Please print in black ink) Completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.**			
Last Name First Name Middle Name			Date of Birth (mo/day/year)	*Social Security #
SECTION A REQUIRED IMMUNIZATIONS				
	(mo/day/year)	(mo/day/year)	(mo/day/year)	(mo/day/year)
Tdap (Tetanus-Diphtheria-Pertussis): one dose **ADULT**				
Td (Tetanus) Booster-Clinical agencies require one vaccine every ten years				
COVID-19 Vaccination: Indicate whether it is one dose or two doses				
MMR (after first birthday)				*****Titer** Date & Result (attach lab result)
MR (after first birthday)				*****Titer** Date & Result (attach lab result)
Measles** (after first birthday) (Clinical agencies require proof of vaccine or titer only)				*****Titer** Date & Result (attach lab result)
Mumps** (Clinical agencies require proof of vaccine or titer only)				*****Titer** Date & Result (attach lab result)
Rubella** (Clinical agencies require proof of vaccine or titer only)				*****Titer** Date & Result (attach lab result)
Hepatitis B series only OR **Hepatitis A/B** combination series				*****Titer** Date & Result (attach lab result)
Varicella (chicken pox) series of two doses or immunity by positive blood titer (Clinical agencies require proof of vaccine or titer only)				*****Titer** Date & Result (attach lab result)
Influenza (Clinical agencies require proof of vaccine)				
Tuberculin (PPD) Test (2 step within **1 to 3-week** period) **Date Read** **mm induration**				
Chest x-ray, if positive PPD results Date Treatment if applicable Date				
SECTION B RECOMMENDED IMMUNIZATIONS			The following immunizations are recommended for all students.	
Meningococcal	Received the meningococcal vaccine. No ☐ Yes ☐			
If yes, please indicate date(s) vaccine was received. (mo/day/year)				
SECTION C OPTIONAL IMMUNIZATIONS	mo/day/year		mo/day/year	mo/day/year
• Pneumococcal				
• Hepatitis A series only				

Revised: 2015, 2019, 2021, 2022

Immunization Signature Page

Signature or Clinic Stamp REQUI RED:

Signature of Physician/Physician Assistant/Nurse Practitioner	**Date**
Print Name of Physician/Physician Assistant/Nurse Practitioner	**Area Code/Phone Number**

Office Address

City	**State**	**Zip Code**

********NO WRITING BEYOND THIS POINT. FOR OFFICE USE ONLY. *******

Immunizations reviewed ____

Reviewer's Signature ____

COMMENTS:

Revised: 2015, 2019, 2021, 2022

PHYSICAL EXAMINATION *(Please print in black ink)* ***Completed*** *and* ***signed*** *by* ***provider***

A physical examination is required by **some schools and/or programs** (consult your college or department for specific requirements). **If required**, it must be completed in black ink and signed by a licensed provider.

Last Name First Name Middle Name	Date of Birth (mo/day/year)	*Social Security Number
Permanent Address City State Zip Code		Area Code/Phone Number

Height ___________ Weight___________ TPR ___________/_________/___________ BP ________/_______

Vision: Corrected Right 20/ _______ Left 20/ ______

Uncorrected Right 20/ _______ Left 20/ ______

Color Vision ______________________________

Hearing: (gross) Right __________ Left __________

15 ft. Right __________ Left __________

IF APPLICANT NEEDS THIS TESTING

Urinalysis: Sugar:__________ Albumin _____________
Micro ________________________

Hgb or Hct (if indicated) ____________________

STS (may be required by some departments)

Date ____________ Results ___________________

Recommendations ______________________________

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes ________ No __________
Explain ____

B. Is student under treatment for any medical or emotional condition? Yes ________ No __________
Explain ____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited ________ Limited __________
Explain ____

D. Is student physically and emotionally healthy? Yes ________ No ________
Explain ____

***** MUST BE COMPLETED BY HEALTH CARE PROVIDER*****

Based on my assessment of this student's physical and emotional health on ____________________________, he/she appears able to
(Date)
participate in the activities of a health profession in a clinical setting. Yes_________ No______ if no, please explain _________
____

____ ____________________________
Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

____ ____________________________
Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

____
Office Address **City** **State** **Zip Code**

Revised: 2015, 2019, 2021, 2022