PRACTICAL NURSING PROGRAM
STUDENT MEDICAL RECORD

Student Name: _____ Student ID#: _____

This Medical Record consists of two sections
Section I is to be completed by the student
Section II is to be completed by the healthcare provider.

Note: Please obtain your immunization record prior to seeing your Healthcare Provider.

Dear Healthcare Provider:

_____ has been offered a position in the New River Community and Technical College School of Practical Nursing. The West Virginia State Board of Examiners for Licensed Practical Nursing mandates that each student has a complete physical examination, current immunizations and the following laboratory tests.

1. Please order complete blood count, VDRL, RPR or STE Serology

2. Review student's immunization record. If the student cannot produce an immunization record, titers will be required to verify immunization. If student does not have immunity or has not received appropriate immunizations, please administer them or refer the student for immunizations. (Refer to page 6)

3. Please complete section II of the Medical Health Examination Record. There is an area on the record of the physical examination for you to record the results of the lab studies? please attach a copy of them to the form.

4. Sign and date the form.

Allow me to thank you in advance for the timely consideration of this matter.

Sincerely,

JoAnna Perry, RN, BSN
Director New River CTC – Practical Nursing Program

New River Community and Technical College School of Practical Nursing

MEDICAL HEALTH EXAMINATION RECORD

Section I

Name: _____

Address: _____

Date of Birth: _____ Telephone: _____

Person to be notified in case of illness or emergency:

Name	Relationship	Telephone Number

List all prescriptions and over-the counter medications you take regularly or occasionally, along with any medical conditions for which these medications are necessary.

_____

List any allergies: _____

Have you been seen by a healthcare provider in the past year?

_____YES _____NO If so, why? _____

Have you had any x-ray and/or major diagnostic study during the past year?

_____YES _____NO If so, why? _____

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Are you currently under medical treatment?

_____YES _____NO

If so, specify medical condition and healthcare provider's name and address:

_____
_____
_____
_____
_____
_____
_____

List any health problems you have had:

_____

Condition	Now/Yes	Past	No
Anemia			
Alcoholism			
Arthritis			
Asthma, Chronic Bronchitis			
Back Problems			
Bone Disease			
Bleeding Tendency			
Cancer			
Chest Pain			
Chicken Pox			
Diabetes			
Drug Abuse/Addiction			
Ear or Eye Disease			
Heart Disease			
Hepatitis			
High Blood Pressure			
Hospitalizations	N/A		
Jaundice			
Kidney Disease			
Measles			
Mental Disorders			
Migraine Headaches			

Mononucleosis			
Nervous Disorder			
Pleurisy or Lung Disease			
Poliomyelitis			
Rheumatic Fever			
Seizure Disorders			
Serious Accident or Injury			
Sexually Transmitted Diseases			
Shortness of Breath			
Skin Disease			
Stomach/Intestinal Diseases			
Surgical Operations			
Syphilis			
Tuberculosis			
Thyroid Fever			
Varicose Veins/ Phlebitis			
Visual Problems			

Directions: Please print the requested information about your family history.

Relation	Age	Medical conditions, if deceased, list cause of death
Father		
Mother		
Siblings		

Additional Information:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section II

To be completed by the healthcare provider

How long has this client been under your care?

_____

When did this client have her/his last complete physical exam? _____

A. Vital Signs: _____
B/P TPR Height Weight

B. Vision: _____
OD OS Comments

C. Hearing: _____
AD AS Comments

D. Check deviations from normal:

_____ Nose and Sinuses

_____ Throat and Neck

_____ Mouth and Teeth

_____ Skull and Scalp

_____ Lymphatic System

_____ Breasts

_____ Lungs/Chest

_____ Arteriosclerosis

_____ Heart

_____ Thyroid

_____ Upper Extremities

_____ Muscular Size & Strength

_____ Hernia

_____ Genitourinary

_____ Gynecological

_____ Anorectal

_____ Varicose Veins

_____ Feet

_____ Lower Extremities

_____ Neurological

_____ Psychiatric

_____ Skin

_____ Eyes

_____ Orthopedic (Posture/spine)

SECTION II (cont'd)

E. In the space below please provide details of the deviations from normal noted in Section D. Please list any prescribed medications for this client:

_____
_____
_____

F. Please review the client's immunizations record. If client needs titers to demonstrate immunity, please obtain the necessary lab work and attach a copy to this form.

I hereby certify that:
(Miss, Mrs., Mr.) _____
has the following immunizations:

Vaccine	Recommendation	Titer Result if Required	Date of Vaccine
Hepatitis B	If no documented evidence of the complete HepB series or if you do not have an up to date blood test that shows you are immune to Hepatitis B. (i.e., no serologic evidence of immunity or prior vaccination) then you should • get the 3 dose series • get anti-HB's serologic tested 1 – 2 months after dose #3		
MMR (Measles, Mumps & Rubella)	If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to measles or mumps (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of MMR. If you were born in 1957 or later and have not had the MMR vaccine or if you don't have an up-to-date blood test that shows you are immune to rubella, only one dose of MMR is recommended. However, you may end up receiving 2 doses, because of the rubella component is in the combination vaccine with measles and mumps. For Health Care Workers born before 1957 see the MMR ACIP vaccine recommendations.		
Varicella	If you have not had chickenpox, if you haven't had the varicella vaccine, or if you don't have an up-to-date blood test that shows you are immune to varicella (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of the varicella vaccine, 4 weeks apart.		
Tdap (Tetanus, Diphtheria, Pertussis) or TD Booster	Get a one-time dose of Tdap as soon as possible if you have not received Tdap previously (regardless of when previous dose of Td was received). Get Td boosters every 10 years thereafter. Pregnant HCW's need to get a dose of Tdap during each pregnancy.		

G. Laboratory test Results: Please provied date completed and attach a copy of results.

CBC: _____

STD Serology/RPR: _____

2 Step PPD:

1st Injection	Results 48-72 hrs	2nd injection 14 days from first injection	Results 48-72 hrs.
Date:	Results:	Date:	Results:

Chest X-Ray; (if indicated) _____

H. Any medical diagnosis made: _____

I. Any working conditions this individual is to avoid?
_____
_____
_____

J. Extent to which applicant may engage in gainful employment.

None_____ Part-time_____ Full-time _____

K. Recommendations:

Do you consider the individual mentally and physically able to undertake the program in Practical Nursing? Yes_____ No _____

L. Date of Examination: _____

M. _____
Signature of Examining Healthcare Provider Date

N. Healthcare Provider's Address and Telephone Number:

_____
Street City State Zip Code

_____
Area Code Telephone Number Extension