

Jefferson Community College

Watertown, New York

Health Information for Freshman Nursing Students

Completed information must be returned to Heather Natali, Senior Secretary - Nursing, Bldg.5, Rm. 211 (Gregor) by July 15 for Freshman nursing students.

PPDs (must read & follow requirements on last page) can be obtained for a fee at:

- Jefferson County Public Health Department, 315-786-3730 on Wednesdays, 12:30 pm – 3:30 pm; **by appointment only**
- North Country Family Health - Health & Wellness Center at Jefferson Community College, 315-786-1042; **by appointment only**
- Most local Urgent Care Centers
- Through many primary care physician offices

If you have questions regarding your health clearance, or need assistance in completing these requirements timely, please contact Heather, Senior Secretary – Nursing at 315-786-2319 or hnatali@sunyjefferson.edu.

CPR cards (American Heart Association) must be renewed annually. This must be completed **before** the first day of class. CPR certification proofs are to be provided to the nursing department secretary, Heather Natali, no later than September 1.

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HEALTH REPORT AND PHYSICAL EXAMINATION

Basic to good student health care is the College's knowledge of the health status of each student. This physical for clinical rotations is the foundation of each student's medical record at the College and thus is a critical element in that knowledge. The information provided by this form will be reviewed by the College's Health Care professional staff in the Health office. It is then filed in the Nursing program office.

The authority to request this information is found in Section 355 of the Education Law.

You will not be allowed to attend your clinical rotation until this form is complete and submitted to the Nursing program office for review.

The Nursing faculty will be notified when a student is cleared to attend clinical.

An accurate medical record enables better health service and health guidance of a student than would be possible without it. For this reason, it would be appreciated if considerable care is used in filling out this form.

Consent to Release Health Information - I am aware and understand that: In order to maintain the health and safety of their clients and meet designated health laws, agencies used for clinical and/or field placement experience may require selected information from my health record. I authorize release of this required information to said agencies and to the program faculty.

Date	NAME (Print Legibly)	Signature of Student
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Date	Witness* - Print (<u>JCC Faculty or Staff Member Only</u>)	Signature of Witness
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Emergency Contact: _____ Phone Number: _____
 (Name and Relationship)

RETURN FORM TO: Heather Natali, Senior Secretary – Nursing, Building 5 (Gregor), Rm 211, Jefferson Community College 1220 Coffeen St., Watertown, NY 13601, either in person, by mail, or email to hnatali@sunyjefferson.edu

Complete for Examining Health Care Provider

J#

Name:

Date of Birth:

_____ Last First _____

Address

_____ Street City State Zip _____

Social Security Number _____ Phone No: _____

Emergency Contact: _____

Address if different from yours: _____

Primary Provider: _____

Address: _____

Phone No: _____

PERSONAL HISTORY:

Circle the following diseases or conditions you have had or have at present:

- | | |
|-------------------------|---------------------------------|
| Alcohol/Substance Abuse | Epilepsy/Seizure Disorder |
| Anorexia | Eye, ear, nose, throat disorder |
| Asthma | Heart condition |
| Bronchitis | High blood pressure |
| Bulimia | Intestinal Disorder |
| Back Problems | Kidney disease |
| Blood Disorders | Bone/Joint Disorder |
| Diabetes | Tuberculosis or TB contact |
| Emotional disorder | |

Comment on all circled conditions in space below: _____

Severe Injuries/Operations: _____

Food/Drug/Environmental Allergies: _____

Any other medical conditions: _____

Please list all medications, including OTC, you are currently taking: _____

Name: _____ Date of Birth: _____

PHYSICAL EXAMINATION

Gender: _____ Age: _____ Height: _____ Weight: _____

Blood Pressure: _____ L/R arm Pulse: _____

Vision: Far: Right 20/ _____ Corr- to 20/
 Left 20/ _____ Corr- to 20/

System	Circle One	Description
General appearance	Normal or Abnormal	
Skin	Normal or Abnormal	
HEENT	Normal or Abnormal	
Neck	Normal or Abnormal	
Lungs	Normal or Abnormal	
Heart	Normal or Abnormal	
Abdomen	Normal or Abnormal	
Musculoskeletal	Normal or Abnormal	
Reproductive	Normal or Abnormal or Deferred	
Psychiatric	Normal or Abnormal	

To the best of my knowledge this student is free from physical or mental impairments including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior altering substances which might interfere with the performance of his/her duties or would impose a potential risk to patients or personnel.

Comments: _____

Examining Health Care Provider (MD, DO, NP, PA) _____ Date _____

Address _____ Phone _____

J# _____

Name _____

Date of Birth _____

NURSING AND ALLIED HEALTH STUDENTS CLINICAL REQUIREMENTS

Please provide documented proof of the following to the Nursing program office:

1. **Mantoux Tuberculin SkinTest (PPD) within 90 days of clinical - required:** Please review the information below and complete the requirement applicable to you:
 - First time receiving a PPD or more than 12 months since last PPD = Two Step Method** (requires two PPDs): must submit copy of both PPDs, or
 - Had a PPD within past 12 months = One PPD:** must submit copy of both PPDs

PPD Test #1: *Most current PPD must be no more than 90 days before beginning clinical experience* (if another PPD within 12 months, must also provide that copy).

- PPDs must be read within 48-72 hours after placement of PPD skin test

Date 1st PPD placed _____

Person/Title placing test _____

Date PPD read _____ Result documented in millimeters _____ mm

Person/Title reading test _____

If at any time a PPD is positive, NO more PPDs to be placed, and will need an (FDA) approved blood assay for the detection of latent tuberculosis infection. Positive blood assay requires chest x-ray, appropriate clinical follow-up and TB exam form (obtain from Nursing Department).

- If 1st PPD is negative, then 2-step PPD placed a minimum 7 days after 1st PPD

PPD Test #2 - Two Step PPD Testing (placed a minimum of 7 days after PPD #1):
Most current PPD must be no more than 90 days before beginning clinical.

Date PPD placed _____

Person/Title placing test _____

Date PPD read _____ Result documented in millimeters _____ mm

Person/Title reading test _____

2. Tdap (Tetanus/Diphtheria/Pertussis): Required Current Tdap (or past Tdap)
3. Varicella: Two-part series or lab work demonstrating immunity
4. MMR Series (measles, mumps, and rubella) or lab work demonstrating immunity
5. Hepatitis B Series: Completed/In-Process Hep B Series, or annual Hep B declination
6. Influenza vaccination: Required annually for nursing – due in late October
7. COVID vaccination/booster: Recommended for all Nursing students