Report of Medical History

Jefferson County-DuBois AVTS
Practical Nursing Program
576 Vo Tech Road
Reynoldsville, Pa 15851
(814) 653-8420
Fax: 855-479-6809

Office Use Only

Date completed: _____

Signature: _____

Flu vaccine verification date: _____

Covid-19 vaccine dates: _____
_____

ATTENTION: Health care Provider:

A physical examination is necessary for the Practical Nursing student to document their ability to meet the demands of the profession without hazard to themselves or others. Proof of immunity to required and is found in Section IV. Please fax this completed form, documents and any appropriate test results to the above address.

I. Demographic Data Completed by the Student:

Name _____ DOB: _____
Last (print) First M.I.

Address _____ _____
Street City/Town/State Zip

Home Telephone _____ ☐ Male ☐ Female

Emergency Contact Information:

_____
Name Relationship Address Phone

Insurance Carrier _____
Company ID # Group #

Present Medications _____

Allergies _____ Reactions _____
_____

LATEX ADVISORY: *The use of latex/latex-based products may exist as health care standard precautions and in environments such as, but not limited to, classrooms and training labs, hospitals, nursing care facilities, laboratories, clinical areas and medical/dental offices. Individuals with latex allergies should seek expert advice from their health care provider so that they may receive information to make an informed decision regarding their exposure to latex in the health care field.*

Additional Vaccines: May be required per clinical agency policy.

I hereby give permission to release required information from my Report of Medical History and a copy of my criminal record background check (Act 34 Clearance) to each facility that I will attend as a student practical nurse.

Signature of Student _____ Date _____

Sections II through IV and certification to be completed by primary care provider.

II. Medical History completed by primary care provider:

Give significant details, regarding serious illness, surgeries, accidents, etc.

III. Physical Examination completed by primary care provider:

Date of Birth ____/___/____ Height _____ Weight _____

T/P/R _____ BP _____/_____

Vision Acuity _____ Vision Corrected: _____20/_____ (L)

Color Blindness _____ _____20/_____ (R)

HEENT: _____ Hearing Assessment: _____

Cardiopulmonary: _____ Neurological: _____

Abdominal: _____ Musculoskeletal: _____

Back: _____ Rectal/GU: _____

General: _____

Please forward results of Urinalysis Drug Screen Report to Jeff Tech Practical Nursing Program.

Fax# 855-479-6809

Name: _____ **DOB: _____**

IV. Proof of Immunity verified by Primary Care Provider: ☐ **See attached immunization documentation**

Rubella (German Measles)	Born before 1957	**OR**	Documentation of 2 doses **LIVE** vaccine (Rubella or MMR) after 1968 1._____ 2. _____	**OR**	Immunity by Titer Date: _____ Result: _____
Rubeola (Measles)	Born before 1957	**OR**	Documentation of 2 doses **LIVE** vaccine (Rubeola or MMR) after 1968 1._____ 2. _____	**OR**	Immunity by Titer Date: _____ Result: _____
Mumps	Born before 1957	**OR**	Documentation of 2 doses **LIVE** vaccine (MMR) after 1968 1._____ 2. _____	**OR**	Immunity by Titer Date: _____ Result: _____
Varicella (Chicken Pox)	Documentation of 2 doses **LIVE** virus vaccine 1._____ 2. _____			**OR**	Immunity by Titer Date: _____ Result: _____
Tdap	Booster within 10 years _____				
***Hepatitis B**	Initial vaccinations series 1. _____ 2. _____ 3. _____ Proof of vaccination necessary. Please forward documentation of Hepatitis B #2 and #3 when completed if necessary.	**A N D**	Hepatitis B titer if vaccinated more than 15 years ago Date: _____ Result: _____	**AND** if negative for immunity	Hepatitis B Booster Date: _____ Result: _____
COVID-19 Series will need a copy of your card	Initial vaccination series 1. Date_____Manufacturer_____ 2. Date_____Manufacturer_____		Boosters 1. Date_____Manufacturer_____ 2. Date_____Manufacturer_____		
***Influenza (Flu)**	Date_____				
Tuberculin Skin Test (PPD/Mantoux) **Required within 60 day start of school**	**Single Step** if acceptable negative 2 Step PPD/Mantoux OR **2 Step** if: (see clarification) ▪ never tested before ▪ no documentation of prior testing ▪ tested negative more than 12 months ago 1. Given: _____ Read: _____ 2. Given: _____ Read: _____			**If positive**	If student has received BCG Date: _____ Chest X-Ray within 12 months start date: _____

Health Care Provider Signature: _____ Date: _____

V. Program Performance Standards read and completed by BOTH primary care provider AND student.

ISSUE	STANDARD	STUDENT EXPECTATION
Independent Cognitive Problem Solving	Problem solving sufficient for clinical judgment.	Competent timely patient assessments; correct assessment interpretations; readily respond with appropriate interventions, treatment plans; ability to work alone and to make correct, independent decisions within scope of practice.
Interpersonal	Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural and intellectual backgrounds.	Life and death situations; working with families stressed by the condition of a loved one; working with other health care providers in a professional manner.
Communication	Communication abilities sufficient for interaction with others in verbal and written form.	Can follow verbal and/or written instructions; must communicate with others; documentation of therapeutic procedures performed on patient; consult with other health care providers in a professional manner.
Mobility	Physical abilities sufficient to move from room to room and walk in hallways, maneuver in small spaces; includes the strength necessary to lift patients, as needed.	Walking to and from departments to patient rooms; ambulating room to room to care for patients on a team; assisting in patient transport.
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective nursing care.	Perform vital signs, CPR, transporting patients, physical assessment, and manipulate equipment.
Hearing	Auditory ability sufficient to monitor and assess health needs.	Auscultation of BP, breath sounds, heart sounds, bowel sounds, hearing alarms in units, call bells, telephones; converse with patients, family and staff.
Visual	Visual ability sufficient for observation and assessment necessary in nursing care.	Reading patient charts/flow sheet/monitors; drawing up and administering medications; assessment patient skin color; reading thermometers.

I believe I can satisfactorily perform the above standards. _____

Student Signature/Date

VI. Certification

I hereby certify that _____ was examined by me on _____ and found in **good physical and mental health**, able to undertake the training of this program, and perform the program standards as stated. In addition, the individual has been advised of exposure to latex/latex-based products in health care environments and the associated potential health risks for individuals with sensitivities or allergies.

I have reviewed this form and completed sections II-VII. In my opinion, all areas are satisfactory to practice in the capacity of a student nurse.

_____ _____

Health Care Provider Signature / Date | Health Care Provider Name (Print)

_____ Licensed as a (MD DO PA CRNP)

License Number / State/Country Licensed

Telephone: ( ) _____ Address: _____

Baseline Testing: Two-Step Test

Two-step testing with the Mantoux tuberculin skin test (TST) should be used for baseline or initial testing. Some people with latent TB infection has a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection.

Step 1

Administer first TST following proper protocol

Review result

- Positive — consider TB infected, no second TST needed; evaluate for TB disease.
- Negative — a second TST is needed. Retest in 1–3 weeks **after first TST result is read.**

Document result

Step 2

Administer second TST 1-3 weeks after first test

Review results

- Positive — consider TB infected and evaluate for TB disease.
- Negative — consider person not infected.

Document result

10 panel DRUG SCREENING Please forward results of Urinalysis Drug Screen Report to Jeff Tech Practical Nursing Program. Fax no. 855-479-6809.