 **CONTRA COSTA COLLEGE**

**Nursing Assistant Training Program Medical Evaluation Form (New Student)**

STUDENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MALE  FEMALE 

Last First Middle

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student I.D.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTH DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Required Titers**: ***ALL LAB RESULTS MUST BE ATTACHED*** (Negative results require vaccinations)

**Titre Results** *(Pos =*  Neg = ── )

Rubella Date of Test \_\_\_\_\_\_\_\_\_\_\_\_\_  ── Vaccination Dates 1)\_\_\_\_\_\_\_\_\_\_ 2)\_\_\_\_\_\_\_\_\_\_\_

Rubeola Date of Test \_\_\_\_\_\_\_ \_\_\_\_\_  ── Vaccination Dates 1)\_\_\_\_\_\_\_\_\_\_\_

Varicella Date of Test \_\_\_\_\_\_\_\_\_\_\_\_\_  ── Vaccination Dates 1)\_\_\_\_\_\_\_\_\_\_\_ 2)\_\_\_\_\_\_\_\_\_\_\_

Hepatitis B Date of Test \_\_\_\_\_\_\_\_\_\_\_\_\_  ── Vaccination Dates 1)\_\_\_\_\_\_\_\_\_\_ 2)\_\_\_\_\_\_\_\_\_\_ 3)\_\_\_\_\_\_\_\_

Mumps Date of Test \_\_\_\_\_\_\_\_\_\_\_\_\_\_  ──. or/MMR Vaccination Dates: 1)\_\_\_\_\_\_\_\_, 2)\_\_\_\_\_\_\_\_

Pertussis (DPT/Tdap) Date of Test \_\_\_\_\_\_\_\_  ── Vaccination Dates 1)\_\_\_\_\_\_\_\_\_\_ (within 10 years)

Influenza / H1N1 (Due each Fall) Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Covid Vaccine (Manufacturer) #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Manufacturer) #2\_\_\_\_\_\_\_\_\_\_\_ Covid Booster #1\_\_\_\_\_\_\_\_\_\_\_Covid Booster #2\_\_\_\_\_\_\_\_\_\_\_\_\_

Covid Booster#3\_\_\_\_\_\_\_\_\_\_\_\_ Note: Covid booster within 6 months required

\* TB **2 Step PPD** 1) Date of Test \_\_\_\_\_\_\_\_\_\_\_\_\_ ── 2) Date of Test \_\_\_\_\_\_\_\_\_\_\_\_\_  ──

*\* 2 step PPD: required annually of all students entering the Nursing Program. That is, two TB skin tests separated by 1 to 3 weeks will be needed.* **QuantiFERON is accepted** *Skin test should not be repeated if the previous test was positive. Positive results require a chest x-ray🡪NOTE: If Positive TB, attach results of* ***base-line X-ray*** *( repeated every five years) MUST HAVE annual M.D.’s note specifying TB symptoms reviewed and negative. State clearance for clinical participation. (Pos =* Neg = ── )

2. **Laboratory Finding**:***ALL LAB RESULTS MUST BE ATTACHED*** CBC & Differential  UA routine 

3. **Is there any significant medical history**: Yes  No  If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. **Is there any health condition that would create a hazard to this student, employees, or patients or visitors**: Yes  No  If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Report of Health Status**

1. Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. Hernia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Heart \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10. Orthopedic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Lungs (No TB sx)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 11. Hearing Test Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Mouth and Teeth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Throat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 12. Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Skin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 13. Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Eyes Vision Test Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Findings: R eye \_\_\_\_\_\_\_\_\_\_\_ L eye \_\_\_\_\_\_\_\_\_\_\_

8. Vision with Glasses Findings: R eye \_\_\_\_\_\_\_\_\_\_\_ L eye \_\_\_\_\_\_\_\_\_\_\_

**Examining Physician/ Nurse Practitioner: Signature certifies nursing student is medically cleared for clinical practice.** Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(rev 11/23)