



**Williamsburg Technical College
Student Health Record
Health Science-Nursing Program**

Please print in ink or type Section I before going to your physician for examination. Be sure to answer all questions fully. Information will not be released to unauthorized persons without your written consent. The student must bring the completed "Student Health Record" to program orientation. Students will not be permitted into clinical facilities without a completed record.

If you have questions concerning a disability, or if requesting reasonable accommodations contact Student Service at 843-355-4169. If requesting accommodations, you must provide appropriate medical, psychological, physiological and/or psychiatric documentation to support this request.

SECTION I (to be completed by student)

NAME _____
(Last) (First) (Middle)

Home Address _____
(Number and Street) (City) (State) (Zip Code)

Social Security Number _____ Birth Date _____

Telephone _____
(Home) (Cell) (Work)

Dr./Nurse Practitioner/Physician Assistant

Signature: _____

PAST MEDICAL HISTORY

Have you ever had?	YES	NO
Rubeola	YES	NO
Rubella	YES	NO
Mumps	YES	NO
Chicken Pox	YES	NO
Infectious Mono	YES	NO
Positive TB Skin Test	YES	NO
Recurrent Herpes Viruses	YES	NO
Sexually Transmitted disease	YES	NO
Heart disease	YES	NO
Heart Murmurs	YES	NO
Mitral Valve Prolapse	YES	NO
High Blood Pressure	YES	NO
Rheumatic fever	YES	NO
Diabetes	YES	NO
Epilepsy/Convulsions	YES	NO
Kidney/Bladder Abnormality	YES	NO
Stomach/Intestinal Abnormality	YES	NO
Arthritis	YES	NO
Asthma	YES	NO
Hay Fever	YES	NO
Color blindness	YES	NO
Recurrent headaches	YES	NO
Back problems	YES	NO
Organ transplant	YES	NO
Insomnia	YES	NO
Frequent Anxiety	YES	NO
Frequent Depression	YES	NO
Worry or Nervousness	YES	NO
Hepatitis (specify A, B, C, D, E)	YES	NO
Allergies:		
Other:		

Dr/ Nurse Practitioner/ Physician

Signature: _____

If you answered “yes” to any question, please give dates and treatments:

Please list any other medical conditions not addressed above:

Please list all medications that you are currently taking:

Dr./ Nurse Practitioner/ Physician Assistant.

Signature: _____

Section II: PHYSICAL EXAMINATION (To be completed by the physician, physician assistant, or nurse practitioner)

Directions: Please review Section I completed by the student and then complete all of the following items in Section II.

Height _____ Weight _____ Blood Pressure _____
 Corrected Vision: Right 20/ _____ Left 20/ _____

(Please circle)

(Please circle)

Hearing: Right: Normal Impaired Left: Normal Impaired

A. Does the student have any abnormalities in the following systems? (Give dates, description of abnormality and treatment of ALL findings. See Below)

System	Yes	No
Eyes	Yes	No
Ears	Yes	No
Nose, Throat	Yes	No
Neurological	Yes	No
Respiratory	Yes	No
Cardiovascular (including murmurs)	Yes	No
Gastrointestinal	Yes	No
Musculoskeletal	Yes	No
Metabolic/Endocrine	Yes	No
Genitourinary	Yes	No
Skin	Yes	No
Immunological	Yes	No
Psychiatric	Yes	No

B. If you have answered “yes” to any item in A. above, please complete the following: (Record additional information on back of this page.)

Date	Diagnosis	Treatment

Dr./ Nurse Practitioner/ Physician Assistant:

Signature: _____

C. MANDATORY Immunization/Tests

- a. Each student must submit a copy of their childhood immunizations. You must have had a **Rubeola, Rubella, Mumps, and Varicella vaccine**. If you have not had these vaccines but had the illness as a child, then you will need a titer to check for immunity and a booster if not immune.
- b. Each student must have a titer drawn for **Rubeola, Rubella, Mumps, and Varicella** for clinical and show immunity. If non-immune, then a vaccine is required. Some vaccines are required in more than one dose, for example, if you have never received the Varicella vaccine, it is a two-dose vaccine administered 30 days apart.
- c. Each student must also provide documentation of a **Flu Vaccination, COVID-19, and a Hepatitis B Vaccine** or a signed waiver declining the Hepatitis B Vaccine.
- d. Copy of **TDAP** Vaccine administered within the last 10 years.
- e. A **2 step PPD or QuantiFERON-TB Blood Test** drawn that will be good for one year.

Please use the form below for documentation purposes or attach a copy from your physician's office or the Health Department.

Vaccine Must have a Dr. or nurse signature	Date of Immunization and Titer (give results and state immunity of titer)		
Rubeola (two live vaccines) 1 month apart	#1	#2	Titer:
Rubella	Date:		Titer:
Mumps	1 st Date:		Titer:
	2 nd Date:		Titer:
Flu Vaccination (Provide Documentation of)	Date:		Site:
	Lot #:		Signature:
Hepatitis B (or attach signed waiver declining vaccine)	#1		
	#2		
	#3		
Varicella (for Nursing and Phlebotomy): immunization or titer required. Injections— 1month apart	1 st Date:		Titer:
	2 nd Date:		Titer:
Intradermal TB Skin Test. Needs to be a 2 step PPD 7 days apart. Read at 48 or 72 hours (Tine test no acceptable) See attached form , or a QuantiFERON-TB blood test drawn that will be good for one year	Date:	2 nd Step: (7 days apart)	
	Date:	Result:	
TDAP Polio and Diphtheria Vaccine (Vaccine good for 10 years)	Date:		Titer:
If TB Skin Test is greater than 10mm, a current (within 6 months prior to admission) chest x-ray is required. Date of Chest x-ray _____ Year Positive _____ Medication Taken _____ Treatment completion date _____ Results _____ *If you have ever had a positive PPD or TB, then it is required to have a yearly chest x-ray. The x-ray must state that there is no evidence of TB.			

ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION IN THE NURSING DEPARTMENT.

The following standards are considered essential criteria for participation in the Nursing Program. Students selected for the Nursing Program must be able to independently engage in educational activities and clinical training activities in a manner that will not endanger clients/patient's, other students, staff members, themselves, or the public. These criteria are necessary for the successful implementation of the clinical objectives of the Nursing Program. In order to be admitted, or to be retained in the Nursing Program after admission, all applicants with or without accommodations must:

- Possess sufficient visual acuity to independently read and interpret the writing of all sizes.
- Independently be able to provide verbal communication to and receive communication from clients/patients, members of the health care team, and be able to assess care needs through the use of monitoring devices, stethoscopes, infusion pumps, fire alarms, and audible exposure indicators, etc.
- Possess sufficient gross and fine motor skills to independently position and assist in lifting client/patients, manipulate equipment, and perform other skills required in meeting the needs of nursing care.

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

_____ Date: _____
Print name of Physician, Physician Assistant, or Nurse Practitioner

_____ Date: _____
Signature of Physician, Physician Assistant, or Nurse Practitioner

**Williamsburg Technical College
Two-Step PPD Skin Test**

Name: _____

Step-1

Name of Product Tubersol

Strength of the Antigen 5 U.S. units per test

Lot Number _____ Expires _____

Test Antigen, Dosage, and method 0.1 ml intradermal

PPD Planted: Date: _____ Time: _____ Site _____

Administered By: _____

Read-48 hr: Date: _____ Time: _____ Results _____ mm

OR Interpreted By: _____

Read-72 hr.: Date: _____ Time: _____ Results _____ mm

Interpreted By: _____

Location Administered _____

Step-2

Name of Product Tubersol

Strength of the Antigen 5 U.S. units per test

Lot Number _____ Expires _____

Test Antigen, Dosage, and method 0.1 ml intradermal

PPD Planted: Date: _____ Time: _____ Site _____

Administered By: _____

Read-48 hr: Date: _____ Time: _____ Results _____ mm

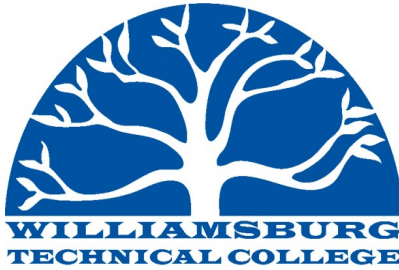
OR Interpreted By: _____

Read-72 hr.: Date: _____ Time: _____ Results _____ mm

Interpreted By: _____

Location Administered _____

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY



Williamsburg Technical College
Hepatitis B Vaccine Waiver Form

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

Signature/Date (high-risk employee- DECLINING)

Signature/Date (witness)