This medical form MUST be completed by the date established in your acceptance letter. Failure to do so may forfeit your placement in the nursing program.

I am aware that during clinical/laboratory experiences there may be a risk of exposure to various communicable/transmissible diseases or illnesses. The College will provide instruction regarding safe health care practices when caring for patients with communicable/transmissible conditions. However, my personal protection against these conditions, that is, following safe health care practices for self and patients and becoming immunized when available, is my responsibility. I must consult with my own physician or the Department of Public Health for assistance or advice regarding immunizations or protection for conditions other than the tests and immunizations included in this physical. I understand that my personal protection against communicable/transmissible conditions is my responsibility. The physician performing this physical examination has permission to release the findings to the JSCC Nursing Education Program. Medical information may be released to clinical affiliates. I attest that this information is true. I am aware that falsification of results will result in disciplinary action which may include dismissal from the Nursing Program.

NOTE: Additional medical examinations and a specific release from a physician may be required at any time (for example, during pregnancy, infectious disease, interference with mobility, emotional instability, etc.) if it is deemed necessary for the faculty to evaluate the state of health.

Student’s Signature: ____________________________ Date: ____________________________

2-step TB Skin Test: (Mantoux only):
You may submit proof of 3 annual negative TB results in place of the 2-step TB testing.

Date: ________________ 48-72-hour Results: ________________ HCP Signature: ____________________________

Students must wait 1-3 weeks between the first and second TB tests.

Date: ________________ 48-72-hour Results: ________________ HCP Signature: ____________________________

Chest X-ray (required only if TB test is positive; suggested for smokers)

Date: ________________ Results: ____________________________

Provider Name (please print): ____________________________ Signature ____________________________

Agency: ____________________________

IMMUNIZATIONS:

- All of the following must be addressed by checking EITHER vaccination OR positive titer – they are not optional.
- If a titer finding is “Non-Immune”, discuss with physician/ CRNP whether you need to restart the series again or obtain a vaccination booster.
- A copy of the actual titer results must be submitted.
- MMR, CP, and Hepatitis B series require 1 month between 1st and 2nd doses. Please keep this in mind when considering the deadline dates posted.

Measles: 1st dose Date: __________ 2nd dose Date: __________ Titer results: □ Immune □ Non-Immune Date: __________
(Rubeola)

Mumps: 1st dose Date: __________ 2nd dose Date: __________ Titer results: □ Immune □ Non-Immune Date: __________

Rubella: 1st Dose Date: __________ 2nd dose Date: __________ Titer results: □ Immune □ Non-Immune Date: __________

Chicken: 1st Dose Date: __________ 2nd dose Date: __________ Titer results: □ Immune □ Non-Immune Date: __________
Pox (Varicella)

Provider Name (please print): ____________________________ Signature ____________________________

Agency: ____________________________
IMMUNIZATIONS (Cont’d):

Hepatitis B: (Must have proof of #1 and #2 injections before participating in clinical activities)
#1 Date: ___________________ #2 Date: ___________________ #3 Date: ___________________
Titer: Date ____________ Titer results: □ Immune □ Non-Immune
(Repeat Adult series x3 per CDC protocol)

Tetanus: Date: ____________________ (must be within 10 years)

Influenza Vaccine Date: ________________ (administer when Seasonal Flu Vaccine/ Mist is available)

Provider Name (please print): ___________________ Signature __________________________
Agency __________________________

Note to healthcare providers:

Students often get immunizations and TB testing at different facilities. HCPs can cross out what is not provided at their facility and still submit the form’s physical exam portion. Students will be responsible for gathering the additional information.

Physical Exam: Students are expected to be in good health as they will deal directly with patients in health care settings. The Nursing Education Program requires proof of a satisfactory level of health and may require proof of physical ability to meet program Essential Functions. Admission or progression may be denied if a student’s level of health is unsatisfactory or if physical limitations prevent a student from maintaining personal or patient safety during campus and clinical laboratories. Students are expected to be physically fit to undertake clinical assignments, be free of chemical dependency, and be mentally competent.

*****Based on the history and your examination, is this student’s mental and physical health sufficient to perform the classroom and clinical duties of a Nursing student? (See Alabama College System Nursing Education Program: ESSENTIAL FUNCTIONS)

►Physician/CRNP’s Initials Required: Yes _____________ No _____________

Additional Comments: ______________________________________________________
__________________________________________

►Physician / CRNP Name (Please Print) ___________________ Signature: __________________________
Address: ____________________________________________ Date of Exam __________________________
__________________________________________ Phone Number __________________________

Revised: 2018