DUE: 08/02/2017

CHABOT COLLEGE
Nursing Program

Report of Medical Examination

Name:				**Date Completed:**	
Address:		**Sex**		**Date of Birth** (MMDDYYYY):	
City:		**Zip:**		**Cell Phone:**	
ZoneMail:	**@zonemail.clpccd.edu**			**Home Phone:**	

HealthCare Provider Signature Required on page 1 and 2

You **MUST** attach hard copy documentation for **ALL** immunization records included the lab results of Titer Report. If PPD positive: Chest X-Ray results with *'Symptom Review'* form is also required.

Test	**Description**	**Test Date**	**Results**
	Two-Step Tuberculosis (PPD) Required		
TB:	1st step between 6/1 - 6/30	PPD #1 Date:	PPD#1 Date and Results
	2nd step between 7/1 - 7/31 **TB test testing should be 2 to 4 weeks from 1st test**	PPD #2 Date:	PPD#2 Date and Results
OR Quantiferon	2017 Results	*Date of Test:*	*Results:*
OR Chest X-Ray	2017 Chest XRay *Must have written verification of positive PPD test*	*Date of Xray:*	*Results:*
Symptom Review	Form must be completed and signed by health care provider and student.	*Date Signed:*	

Titer Report is required RESULTS MUST BE POSITIVE by 06/30 If Negative, Borderline or Non-Immune Results the Student must get *two boosters			**Negative/Borderline Titer ONLY *Vaccine #1 - by 7/15**	**Negative/Borderline ONLY *Vaccine #2 – by 8/15**
MUMPS	Date:	Titer Results:	#1	#2
RUBEOLA (Measles)	Date:	Titer Results:	#1	#2
RUBELLA (German Measles)	Date:	Titer Results:	#1	#2
VARICELLA (Chicken Pox)	Date:	Titer Results:	#1	#2
HEPATITIS B VACCINE	Date:	Titer Results:	#1	#2
(Hep B: 3 doses required but must have 2 doses before starting Nursing Program)			#3	
HEPATITIS C BASELINE	Date:	Titer Results:	***If positive***, a letter from doctor stating the student is not ACTIVELY contagious required.	
TdaP - Tetanus, diphtheria, pertussis Required booster within last 10 years			**Date:**	

HealthCare Provider: Signature required on both		**Date:**	

CHABOT COLLEGE
Page Two Medical Exam

DUE: 08/02/2017

Student Name: _____

TO BE COMPLETED BY EXAMINING HEALTHCARE PROVIDED AND SIGNED

VS: BP_____HR_____RR_____Temp_____Height_____Weight_____

1. Program Requirements include ability to lift without assistance 50 lbs. Students will be required to perform bedside nursing care which involves lifting, moving and transferring patients and equipment without restriction.

   ☐ Yes, student cleared ☐ No, student is unable to lift without assistance.

2. Current complaints or disabilities pertinent to the student's education and clinical practice in a health-related program:
   _____
   _____

3. Significant medical history: major illness, accidents, deformities, surgeries, back problems, etc._____
   _____
   _____
   _____

4. Routine medications:_____
   _____
   _____

5. Examination comments and findings:_____
   _____
   _____

The above named student has no communicable or disabling disease at this time. He/she is able to perform *ALL* of the physical activities required for the program in which the individual is enrolling.

✍_____(_)_____
Health Care Provider Signature (Front and Back of form**)/** Date Phone Number

_____
Health Care Provider Address City ST Zip

**********Student: ***I give my permission to release my immunization records to each affiliating clinical facility. I understand that I <u>will not</u> be allowed to go into the clinical areas until all components of this form are fully met and completed. Required documentation for immunization is attached.***

Student Signature: _____Date:_____

Please return this form to:
Chabot College Nursing Program Office Room 2273 <u>or</u> **25555 Hesperian Blvd. * Hayward, CA 94545**

Original – Nursing Program Office – Students should KEEP A COPY For your records Page 2 of 2