

VIRGINIA APPALACHIAN TRICOLLEGE NURSING PROGRAM
Student Information, Physical Assessment and Immunization Record Form

Directions for form: Student Information on page 1 is to be filled out completely by the student. **Physical Assessment** on page 2 is to be completed by a medical doctor, physician's assistant, or nurse practitioner. **Immunization Record** on page 3 is to be filled out by health care provider, signed and dated. Proof of immunization, such as health department record or lab result must be attached. Do not leave any item blank. It is the student's responsibility to make sure that the form and documentation are complete. Attach this form to the Required Student Forms and Documentation Checklist and return to VATNP, PO Box 828, Abingdon, VA 24212.

Deadlines: Submit by May 15th for LPN- RN or Paramedic-RN bridge students, by August 1st for students entering in the fall semester.

Student Information

Student Contact Information

EMPL ID: _____ Birth Date (MM/DD/YYYY): _____ Academic Year: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Student Email: _____

Home Phone: _____ Cell Phone: _____

Person to Notify in Case of an Emergency

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

In case of emergency I give the Virginia Appalachian Tricollege Nursing Program permission to obtain medical assistance and to notify my emergency contact person (s). Yes _____ No _____ (initial)

I understand that my medical information may be released to clinical agencies as required by agency contracts. Yes _____ No _____ (initial)

BY MY SIGNATURE, I AUTHORIZE THE VIRGINIA APPALACHIAN TRICOLLEGE NURSING PROGRAM TO RELEASE THE INFORMATION ON THIS FORM TO THE AGENCIES WHERE I HAVE CLINICAL LABORATORIES AS REQUIRED BY AGENCY CONTRACTS.

SIGNATURE: _____ **DATE:** _____

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Student Name: _____

Physical Assessment (to be completed by the physician, physician's assistant or nurse practitioner).
 Please check in the YES or NO column to indicate status.

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

Any abnormalities of the following areas?	YES	NO	IF YES, PLEASE EXPLAIN (include current treatments and medications)
Head, Ears, Nose, or Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neurological			
Psychiatric			
Skin			
Lymph Nodes			

Physical and Mental Status	YES	NO	IF YES, PLEASE EXPLAIN (include current treatments and medications)
Is there loss or impaired function of any organ or limb?			
Is there any impairment or lifting restrictions? (Need to be able to individually lift and carry 50 pounds, occasionally lift 51 – 74 pounds, pushing and pulling up to 200 lbs. with assistance, occasional lifting up to 200 lbs. with assistance.)			
Are there any recommendations for any physical or emotional/psychological restrictions?			
Is there any reason the individual cannot physically, emotionally, or psychologically participate in a health care setting as a health care provider?			

Health Care Provider's signature: _____ Date: _____

Print Name and Title: _____

Address: _____

Phone: _____

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Student Name: _____

Immunization Record (to be completed by healthcare professional)

To the clinician: Please indicate date of immunization, disease, lab tests (titers) and initial in “Initials” column. Comments may be written in the NOTES column or under Additional Comments at the end of this page.

TEST	RESULT	DATE	INITIALS	NOTES
Mantoux - if positive attach documentation of chest x-ray	Results in mm	Date PPD read:		Mantoux Tuberculin Skin Test – test must be current. A negative chest X-ray and yearly physician documentation of negative physical signs and symptoms of tuberculosis is required for any positive TB skin test.
VACCINE	DOSE #	DATE	INITIALS	NOTES
MMR (Measles, Mumps, Rubella) OR Individual Shots: Measles Mumps Rubella OR Attach documentation for titers Measles (Rubeola) Mumps Rubella	1			MMR – evidence of two MMR immunizations after the first birthday OR documentation of 2 measles shots and 2 mumps shots and one rubella shot OR attach positive titer showing proof of immunity for measles (rubeola), mumps and rubella.
	2			
	1			
	2			
	1			
	2			
	1			
	Titer			
	Titer			
	Titer			
Hepatitis B	1			Hepatitis-B - evidence of three shot series OR titer showing proof of immunity.
	2			
	3			
	Titer			
	Waiver			
Varicella (Chicken Pox)	1			Varicella – evidence of immunization series OR documented history of disease OR positive titer showing proof of immunity.
	2			
	Disease			
	Titer			
Tetanus-Diphtheria	Td			Td (Tetanus-Diphtheria) – documentation of immunization within the last ten years.
Clinician Signature		Date	Address	
Print Name		Title	Phone	

Additional Comments: