



Health Services Department

Nursing Program

Purpose

Completion of this health packet is mandatory prior to clinical participation to ensure the health and safety of both students and patients. The information you provide will be evaluated against the technical standards that have been validated as essential for participation in the program.

Students

- Please complete Section 1, 2 and 3 of this career packet. Your name and student ID number (M00 #) must be on each page in case the pages become separated. These are fillable PDF forms. You can use your computer to fill in the student fields and then print it out to sign and date using ink or the forms can be completed in ink.
- Completion of this entire packet (including vaccines or waivers, tuberculosis screening and proof of a physical exam done within the past year) is required from each student before submission.
- Please monitor your MCC student email account, as an RN will review your health packet and contact you via student email to let you know if anything else is needed. This process can take up to 72 hours.

Healthcare Providers

- Please ensure that the 2-Step PPD and all of the immunization requirements Section 4 have been met.
- Be sure the four questions on the top of the physical form are completed and signed by the provider. This is a NYS Department of Health requirement for students entering a health career program.

Nondiscrimination Statement: Monroe Community College prohibits discrimination based on race, color, religion, sex, sexual orientation, pregnancy, familial status, gender identity or expression, age, genetic information, national or ethnic origin, physical or mental disability, marital status, veteran status, domestic violence victim status, socioeconomic status, criminal conviction, or any other characteristic or status protected by state or federal laws or College policy in admissions, employment and treatment of students and employees, or in any aspect of the business of the College.



Last Name: _____ First Name: _____ MI: _____

M#: _____ Date of Birth: _____ Age: _____

Cell Phone: _____ Email: _____

Gender: Male Female Student Employee

Please complete this form to assess your potential exposure / possession of COVID-19 and other illnesses.

Are you currently free from illness? Yes No

Do you have: heart disease Yes No

 lung disease Yes No

 kidney disease Yes No

 diabetes Yes No

 autoimmune disease Yes No

During your time away from Monroe Community College, did you experience, or are you currently experiencing any of the following:

Symptoms: *Check all that apply*

Fever Loss of Smell Diarrhea Body Chills Sore Throat

Upset stomach Extreme Level of Fatigue Loss of Taste Cough

Body / Muscle Aches Pain/Difficulty Breathing Shortness of Breath

- 2-14 days prior to experiencing these symptoms, did you experience a suspected exposure to COVID-19?
Yes No
- Have you had any direct contact with anyone who lives in or has visited a place where COVID-19 is spreading and/or is an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?
Yes No
- Have you had any direct contact with someone that has a suspected or lab confirmed case of COVID-19?
Yes No
- During your time away from INSTITUTION, did you self-quarantine due to suspected symptoms or exposure of COVID-19?
Yes No
- During your time away from INSTITUTION, have you been living in, or have visited an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?
Yes No

- Have you previously been or are you currently diagnosed with COVID-19?

Yes No Date of Diagnosis: _____

Do you have medical documentation to support your diagnosis and treatment of COVID-19?

Yes No

Physician Name: _____ Phone: _____

Physician Address: _____

Please list any countries/states/cities you have traveled to since March 15th, 2020 and the dates you were there:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____
4. _____ Dates: _____
5. _____ Dates: _____

COVID Vaccine

Date 1st dose: _____ Product Name/Manufacturer: _____

Date 2nd dose: _____ Product Name/Manufacturer: _____

Signature: _____ Date _____

Student Name _____

M00# _____



Section 1

Nursing Health History Form

Student to Complete

Demographics

Today's Date:	Date of Birth:
Student Address:	
Cell Phone #:	Home Phone #:
Emergency Contact:	Phone:
Primary Doctor Name:	Primary Doctor Phone:
Health Insurance Carrier:	ID Number:

Allergies

Please list all allergies (such as to drugs, bees, latex, etc.)

Substance:	Reaction:	Treatment:
Substance:	Reaction:	Treatment:
Substance:	Reaction:	Treatment:
Substance:	Reaction:	Treatment:

Medicines

Please list all you use, including over the counter medicines

Medicine:	Dose:	Times/Day:	Used For:
Medicine:	Dose:	Times/Day:	Used For:
Medicine:	Dose:	Times/Day:	Used For:
Medicine:	Dose:	Times/Day:	Used For:

Confidential Health History

Mark each that apply, add details or more information below.

ADD	ADHD	Anxiety or Panic Attacks	Asthma	Back Problems
Colitis	Concussions/Head Injuries	Depression	Eating Disorder	
Type 1 Diabetes	Type2 Diabetes	Hearing Impaired/Deaf	Heart Problems	
High Blood Pressure	History of Fainting	Migraines	Neurological Issue	
Severe Menstrual Cramps	Thyroid Issues	Tuberculosis	Uncorrected Vision Problem	
Seizures:	Petit	Focal	Grand	Last Seizure: _____

More Information:

Hospitalizations:

Surgeries:

I attest to the truthfulness of the above statements and that I am free from habituation or addiction to depressants, stimulants, narcotics and other behavior altering substances.

Student Signature: _____ Date: _____

Student Name _____

M00# _____

10. Demonstrate compassion, integrity, empathy, accountability, respect, honesty and a neat, clean professional appearance. Yes No

11. Maintain a level of functioning unimpaired by substances such as alcohol, prescription or illegal drugs. Yes No

12. Maintain emotional health and mental well-being. Yes No

If you answered no, please explain.

Student Must Sign:

I attest to the truthfulness of the information above, and that I am free from habituation or addiction to depressants, stimulants, narcotics and other behavior alerting substances.

Signature: _____ Date: _____



Section 3

Vaccine Requirements

Meningitis

You must choose one option.

1. Provide Proof of a Meningitis ACWY Vaccine received in the past 5 years that is in Section 4, #5.
(If you are not sure if you received this vaccine, or if it was over 5 years ago, decline below for now)

OR

2. Decline the vaccine by signing below attesting that: I have reviewed the information regarding meningococcal disease available at health.ny.gov/publications/2168, in print in the health office, or at Health Services webpage under Immunizations. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal disease. I understand this does not prevent me from receiving the vaccine in the future, from my private health care provider, local health department or the Monroe County Health Department's Immunization Clinic at 111 Westfall Rd, Rochester, NY 14620, (585) 753-5150.

Student Signature (parent if under 18): _____

Date: _____

Hepatitis B

You must choose one option.

1. Provide proof of the Hepatitis B vaccine series that is in Section 4, #4 or a positive immune titer

OR

2. Decline the Vaccine by signing below: (*you are not required to receive the vaccine*)

I understand that due to my possible exposure to blood or body fluids in my training, I may be at risk of acquiring Hepatitis B virus infection, a serious liver disease. I decline the vaccine at this time. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I wish to be vaccinated with the Hepatitis B vaccine, I can receive this vaccine from my physician or from the health care agency that employs me.

Student Signature (parent if under 18): _____

Date: _____



Tuberculosis & Required Immunizations

Provider to complete this section.

Tuberculosis

Student must show proof of one of the following:

- 2-Step PPD Skin Test (Minimum one week apart and maximum within 21 days)
- 1st Tuberculin Skin Test: Date Placed: _____ Date Read: _____
 Result in mm: _____ Result is: Positive or Negative
- 2nd Tuberculin Skin Test: Date Placed: _____ Date Read: _____
 Result in mm: _____ Result is: Positive or Negative
- IGRA Blood Test within past year: Date _____ Result is: _____ Positive _____ Negative
- For those with a new positive TB Test or Known Past Positive:
- Student must show proof of Negative Chest X-Ray completed at any time after the + test.
 Date of Positive Test: _____ Date of Chest X-Ray: _____
 Chest x-ray result: _____ Normal _____ Abnormal
 Treatment or Referral: _____
 - Check Off Any Symptoms Shown in Past Year (Check All That Apply)
 _____ None _____ Night Sweats _____ Unexplained Weight Loss _____ Cough for 3 Weeks
 _____ Unexplained Fever _____ Bloody Sputum _____ Unexplained Fatigue

Signature of Health Care Provider: _____ Date: _____

Immunization Requirements for All Students

1. Proof of Immunity to Measles, Mumps and Rubella by One of The Following:

Two MMR Vaccines #1 _____ #2 _____ OR

Positive IgG Immune Titers: (Attach Test Results or Enter Dates Below):

Rubeola titer: _____ Rubella titer: _____ Mumps titer: _____
2. Proof of Immunity to Varicella by One of The Following:
 - Two Varicella (Chicken Pox) Vaccines: #1: _____ #2: _____
 - Date of Positive Varicella titer: _____ (or you may attach lab results)
 - Date of Varicella Disease Diagnosed by Provider: _____
 - Date of Herpes Zoster (Shingles) Diagnosed by Provider: _____
3. Tetanus Booster in Past 10 Years: Date: _____ Circle One: Tdap Or Td
4. Proof of Immunity to Hepatitis by one of the following (or student may sign the Declination in Section 3)
 - Date of Doses: #1: _____ #2: _____ #3: _____
 - Date of positive Hepatitis B Surface Antibody Titer: _____ (or attach lab results)

If student is in process in the series, student should sign the declination and send in vaccine dates as received.
5. Meningitis ACWY Vaccine within 5 Years (or student may sign the Declination in Section 3)
 - Date: _____
6. Date of Influenza Vaccine for Current Season: _____

Student Name: _____ DOB: _____ M00#: _____

To Be Completed by Health Care Provider.

Physician or health care provider, carefully read the following statement, and check the appropriate boxes.

1. Are there musculoskeletal restrictions related to mobility, range of motion, lifting, or manual dexterity?
 Yes No
 If yes, please explain: _____
2. Are there uncorrected hearing restrictions which would impair the student from hearing audible alarms or engaging in telephone or oral communication with patients? Yes No
 If yes, please explain: _____
3. Are there uncorrected sight restrictions which would impair the student from accurately reading gauges and calibrated equipment? Yes No
 If yes, please explain: _____

I performed the above medical evaluation and found to the best of my knowledge, him/her to be free from physical or mental impairments, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior-altering substances which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel. Yes No

If **NO** is checked, please identify those problems which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel. _____

Allergies: _____

Medications & Supplements: None or _____

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____

Area Examined	Check Below if Normal	Describe Abnormal Findings
• Hand/Skin	_____	_____
• Head/Eyes	_____	_____
• Ears/Nose/Throat/Mouth	_____	_____
• Neck/Nodes	_____	_____
• Chest/Lungs	_____	_____
• Cardiovascular	_____	_____
○ Carotid Arteries	_____	_____
○ Neck Veins	_____	_____
○ Apical Pulse	_____	_____
○ Heart Sounds	_____	_____
• Abdomen	_____	_____
• Musculoskeletal/Extremity	_____	_____
• Musculoskeletal/Spine	_____	_____
• Nervous System	_____	_____
• Genitourinary	_____	_____

Date of Exam (Must Be Within One Year): _____

Health Care Provider's Signature or Stamp (With Title): _____

Print Health Care Provider's Last Name: _____

HCP's Address: _____

Office Phone #: _____ Office Fax #: _____