2016 NURSING PROGRAM PHYSICAL EXAMINATION FORM

NAME: _____

(Last) (First) (Middle)

ADDRESS: _____

(Street or P.O. Box)

_____

(City/Town) (State) (Zip code) (Telephone)

BIRTH DATE: _____

(Month) (Day) (Year)

PLANNED ENROLLMENT DATE IN FULL-TIME NURSING COMPONENT: _____

Semester)(Year)

NOTE: Physical Examination remains valid for admission purposes for one year.

This physical form must be turned in by May 23, 2016 for admission into fall clinical NO EXCEPTIONS.

Part I - PHYSICAL EXAMINATION is to be completed by the physician.

Part II - IMMUNIZATIONS.

Part III – HEALTH INSURANCE

TO THE PHYSICIAN:

The above-named applicant is seeking admission into the Associate in Applied Science Program in Nursing at Blue Ridge Community College. Successful completion of the program leads to licensure as a Registered Nurse. Because admission to the program is selective, it is important that a complete and accurate account of the applicant's health record be received to insure that unforeseen problems do not develop during the course of study in this strenuous program. The College requires completion of all immunizations and tests listed in Part II. If these requirements are not available at your facility, please direct the applicant to the nearest facility for completion of the requirements. Your cooperation in this matter is greatly appreciated.

Part I - PHYSICAL EXAMINATION (to be completed by the physician)

We request a copy of your physical ROS and your general impressions of this applicant.

A. Immunizations and Tests: (see attached page)

B. Certification/Recommendation:

Is there any reason why you would not recommend this applicant for admission in the nursing program?_____

_____

_____

_____

Physician Signature Printed Name of Physician Date

ADDRESS: _____

(Street or P.O. Box)

_____

(City/Town) (State) (Zip code) (Telephone)

PART II - IMMUNIZATIONS

These requirements must be completed for acceptance into the BRCC Nursing Program.

1. Date of Rubella Immunization:_____

   OR Results of Rubella Titer _____

2. Date of Rubeola immunization_____

   OR results of Titer_____

3. Date of Varicella immunization_____

   OR Result of Varicella Titer_____

   OR history of chicken pox_____

4. Dates of 2 step Tuberculin Test_____

   1st date administered: _____1st date read:_____Reaction: _____

   2nd date administered: _____1st date read:_____Reaction: _____

   Lot #_____ Expiration date: _____

   PD must be read no earlier than 48 hours and no later than 72 hours. (If test is positive, a chest x-ray is required)

   If required, results of chest X-ray:_____

5. Date of Tetanus Toxoid:: _____
   Must have received within the past 5 years):

6. Date of Hepatitis B vaccine_____ (Strongly Recommended)
   If you elect not to have the Hepatitis B Vaccine, please read and sign the following:
   Hepatitis Declination: I understand that during my educational and clinical experience in the Nursing Program at Blue Ridge Community College I may have exposure to blood or other potentially infectious materials and may be at risk of acquiring hepatitis B virus (HBV) infection. 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. The BRCC Nursing Department will not be held liable if I should contract the disease.

   _____

   Student Signature Printed Name Date

   _____

   Witness Signature Printed Name Date

7. Flu vaccine_____
   (Strongly recommended, forms for the flu vaccine will be handed out in the fall semester.)

   Flu Declination: If you elect not to have the Flu vaccine, please read and sign the following declination on the next page
   I understand that during my educational and clinical experience in the Nursing Program at Blue Ridge Community College I may have exposure to the flu virus. However, I decline the flu vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring the flu. The BRCC Nursing Department will not be held liable if I should contract the flu. I may be required to wear a protective mask (PPE) at clinical.

   _____

   Student Signature Printed Name Date

   _____

   Witness Signature Printed Name Date

PART II _ Health Insurance

To be completed by the student: Please supply the following information, or read and sign the Health Insurance Declination on following page.
I carry Health Insurance provided by the following company:

Name of Company: _____

Policy Number:_____

Expiration Date: _____

Health Insurance Declination: I understand that during my educational and clinical experience in the Nursing Program at Blue Ridge Community College I may be exposed to blood or other potentially infectious materials and may be at risk of acquiring an infectious disease. However, I decline to subscribe to Health Insurance at this time. I understand that by declining to carry health insurance, I will assume total financial responsibility for any necessary health care needs because they are not covered by hospital insurance or by Blue Ridge Community College.

Student Signature	Printed Name	Date
Witness Signature	Printed Name	Date

Emergency Contact Person for Student: _____

Relation to Student: _____

Emergency Contact Telephone Number: _____

Please return the completed form to:
Nursing Office
Blue Ridge Community College
P.O. Box 80, J131 B
Weyers Cave, VA 24486