# Miles Community College
## Nursing Department

## MCC NURSING BASIC HEALTH SCREENING

**July 15th is the deadline for completion and submission of this form to the Nursing Dept.**

**Miles Community College Nursing, 2715 Dickinson St., Miles City, MT 59301**
**Or email lundk@milescc.edu.**

**Students cannot begin clinical experiences until ALL components are completed and turned in.**

The purpose of the Basic Health Screening is to:

- Ensure that students have met the basic health requirements of contracted healthcare facilities providing student clinical experiences
- Ensure that students are personally protected for practice in the healthcare delivery environment

The health screening must be performed by a licensed primary health care provider, such as a:

- Physician
- Nurse practitioner
- Physician's Assistant

**This information will not be released for secondary submission to another agency or employer.**

Name: Last _____ First _____Middle_____

Permanent Mailing Address:
_____

Date of birth ___/___/____ Gender F M (circle one)

Home Phone_____ Cell Phone: _____ Email _____

**PERSON TO NOTIFY IN CASE OF EMERGENCY**

Name_____ Relationship_____

Address_____ Home Phone_____ Work Phone_____

HEALTH AND HOSPITAL INSURANCE
NAME OF INSURANCE COMPANY_____

ADDRESS OF INSURANCE COMPANY_____

SUBSCRIBER'S NAME_____ POLICY NUMBER_____
**If you do not have health insurance, obtain a Health Insurance waiver form from the Nursing Administrative Assistant or on the nursing website at http://www.milescc.edu/Programs/Nursing/.**
**The waiver must be signed, notarized, and accompany this record.**

**CNA REQUIREMENT**

**I have taken the required CNA course or have attached a copy of my CNA license.** Yes No

Discovery of any incorrect information or falsification of information on the Basic Health Screening form may lead to revocation of acceptance and denial of continuation in the Miles Community College Nursing Program.

**Students are responsible for notifying the Nursing Dept. of any updates or changes in information.**

## TO BE COMPLETED BY STUDENT

## HEALTH HISTORY RECORD

| HEALTH HISTORY | | |
|---|---|---|
| **HISTORY** | **YES** | **NO** |
| Arthritis | | |
| Rheumatic Fever | | |
| Tonsillitis | | |
| Hay Fever | | |
| Epilepsy | | |
| Tuberculosis | | |
| Bleeding Disorders | | |
| Heart Disease | | |
| Urinary Disorders | | |
| Asthma | | |
| Dysmenorrhea | | |
| Emotional Disturbances | | |
| Cancer | | |
| Eczema | | |
| Mononucleosis | | |
| Hepatitis (A-B) | | |
| Handicap Disabilities | | |
| Latex Allergy | | |
| Other | | |

# TO BE COMPLETED BY HEALTH CARE PROVIDER

## PAST HEALTH

Accident or Injuries:

Serious or Chronic Physical and/or Mental Illnesses:

Hospitalization/Surgeries:

*Allergies: Medications and/or Foods
bananas____ avocados ____ kiwi fruit ____ poinsettias ___

Asthma _____***If you have checked any of the above, we strongly recommend a Latex Allergy Blood Test.**

Current Medications:

Other:

## PHYSICAL EXAMINATION

Pulse_____ Resp _____ BP _____Ht _____Wt_____

Eyes _____ Ears _____ Nose _____

Throat _____ Teeth _____ Neck _____

Lymph _____ Lungs _____

Breasts _____ Heart _____ Abdomen _____

Spine and Back _____ Extremities _____ Skin _____

Hernia _____ Date of last GYN exam (if applicable) _____

Reflexes _____ Mental State _____

Motor _____ Sensory _____

**HEALTHCARE PROVIDER, NAME, ADDRESS and PHONE #Name:**_____
_____**Address:**_____
_____**Phone Number:**_____

## Miles Community College Nursing Department

Student's Name _____

**CPR CERTIFICATION**

**I have attached a copy of my current CPR Certification. Yes No (Circle one)**

**My CPR certification is current and valid until _____(date)**

## MILES COMMUNITY COLLEGE HEPATITIS B VACCINATION POLICY

Hepatitis B illness is a potentially fatal disease caused by a virus which can be transmitted through mucus membranes, sexually, perinatally and through non-intact skin. The highest concentration of the virus is in the blood: thus exposure to blood is the most dangerous and "needle sticks" constitute the highest occupational risk for health care workers. Because health care worker are at two to four times greater risk than the general public, The Center for Disease Control has recommended immunization for all health care workers in high risk areas.

Your clinical experience will be in a wide variety of health care settings. This may increase your risk for accidental exposure to Hepatitis B virus. It is therefore **strongly recommended** that you receive vaccination to protect you from this disease.

Vaccination requires three separate vaccines received over a period of six months. Complete immunity will not be established until the end of this time period. It is to your advantage, therefore, to initiate your vaccination early so that you will have complete immunity when you begin your major clinical experiences. **This form must be submitted with either Section A or Section B completed.**

**SECTION A**

I have initiated my Hepatitis B Vaccine, which will be completed by _____
(Date)

_____ _____
(Signature) (Date)

**OR**

I have completed my Hepatitis B Vaccine:

1st Dose:_____(Date) 2nd Dose:_____(Date) 3rd Dose_____(Date)

Reactive titer attached _____(Date)

_____ _____
(Signature) (Date)

**SECTION B**

**I understand the risks, and I choose NOT to protect myself with hepatitis B vaccination at this time.**

_____ _____
**(Signature)** **(Date)**

## TO BE COMPLETED BY HEALTH CARE PROVIDER

**An official copy of Immunization/Vaccination can be used for validation as long as actual dates are listed. If no records of childhood immunizations are available, student may verbally validate.**

## REQUIRED IMMUNIZATION RECORD

**Student's Name**: _____

| REQUIRED IMMUNIZATIONS | |
|---|---|
| **VACCINATIONS** | **DATE/S** |
| Measles, mumps, rubella (MMR) - or hx. of disease | |
| Tetanus, Diptheria, Pertussis (Td/Tdap). Substitute 1st time dose of Tdap for Td booster; then boost with Td every 10 years | |
| Varicella Titer or Hx. of Chicken Pox | |
| Hepatitis A Vaccines (recommended) | |
| Meningococcal Meningitis ( recommended) | |
| PPD (Tuberculin Skin Test)<br>Date given:_____<br>Given by: _____<br>Date read: _____<br>Read by: _____<br><br>Results:<br>Negative: _____<br>Positive: *_____<br><br>**+If PPD is positive, the physician's report of the chest x-ray is required.** | |