

**MERCER COUNTY COMMUNITY COLLEGE
PHYSICAL EXAMINATION REPORT FOR NURSING PROGRAM**

The individual presenting this form has been accepted into the **Nursing** program at Mercer County Community College. Nursing students are required to meet the same health requirements mandated by the NJ Department of Health and JCAHO as employees of any health care facility. Thus, some requirements are in addition to those usually performed as part of a physical examination.

NAME: _____ PROGRAM: NURSING

MCCC PERSONAL IDENTIFICATION NUMBER: _____

IMMUNIZATIONS

Polio Date (if known) _____

Tetanus/ Diphtheria booster (Must be within 10 yrs.) Date _____

Hepatitis B

Series-Dose 1 _____ Dose 2 _____ Dose 3 _____
Date _____ Date _____ Date _____

Screening/Titer Date* _____ Immune Non immune

**NOTE: ONCE SERIES IS COMPLETED, TITER* MUST BE DRAWN AND RESULTS SUBMITTED.
IF CLIENT IS NON-IMMUNE, SERIES MUST BE REPEATED.**

***Quantitative test results required**

LABORATORIES

CBC	DATE: _____	Within Normal Limits?	Yes	No
Urinalysis	DATE: _____	Within Normal Limits?	Yes	No
Rubella Antibody Detection (HAI)**	Date: _____	Immune	Yes	No
Rubeola Antibody Detection**	Date: _____	Immune	Yes	No
Varicella Antibody Titer**	Date: _____	Immune	Yes	No

NOTE: THE rubella, rubeola and varicella screening tests must be performed regardless of client's history.

- **if non-immune to rubella and rubeola, then mmr must be given.**
- **if non-immune to varicella, vaccine is recommended.**
- **ALL LABORATORY REPORTS MUST BE SUBMITTED.**

****IGG titers required**

TWO STEP MANTOUX (PPD)

#1 STEP ADMIN DATE _____ #1 STEP RESULTS _____

#2 STEP ADMIN DATE _____ #2 STEP RESULTS _____

- **NOTE; IF POSITIVE OR CLIENT RECEIVED BCG, A CHEST X-RAY MUST BE TAKEN AT THIS TIME UNLESS ONE WAS PERFORMED WITHIN THE PAST TWO MONTHS. THE RADIOLOGY REPORT MUST BE SUBMITTED.**

The tine or multiple puncture tests are not sufficient

PHYSICAL EXAMINATION

Pulse: _____ **Blood Pressure:** _____ **Height:** _____ **Weight:** _____

Hearing Normal Abnormal Corrected

Vision Normal Abnormal Color Blind Corrected with Glasses

ARE THERE ANY ABNORMALITIES IN THE FOLLOWING?

	Yes	No
EENT	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Emotional	<input type="checkbox"/>	<input type="checkbox"/>
Physical Handicap	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain _____

PHYSICIAN'S STATEMENT

Upon review of the physical exam and lab results, I certify that this student is medically able to perform all clinical activities without restrictions.

MD/NP Signature: _____ Date: _____

Print Name: _____ License # _____

Address: _____

Telephone # _____