Student Name: _____
Student "A" No.: _____

BEVILL STATE COMMUNITY COLLEGE
HEALTH SCIENCE DIVISION
PHYSICAL EXAMINATION

NAME: _____**Student "A" No:** _____
Last First Middle

Phone: _____ **ADDRESS**_____

**********MEDICAL HISTORY**********

ALL SECTIONS to be completed by a health care provider: MD, DO, PA or CRNP Only

Eye/Vision Impairment:	No ____ Yes ____
Ear/Hearing Impairment	No ____ Yes ____
Orthopedic Impairments	No ____ Yes ____
Chronic Respiratory Dx.	No ____ Yes ____
Chronic GI Problems	No ____ Yes ____
Chronic Urinary Problems	No ____ Yes ____
Cardiac/Circulatory Dx.	No ____ Yes ____
Mental/Emotional Disorder	No ____ Yes ____
Integumentary Impairments	No ____ Yes ____
Occupational Disease/s	No ____ Yes ____
Chronic Reproductive Disorder	No ____ Yes ____
Allergies: (Food or Drug)	No ____ Yes ____
Seizure Disorder	No ____ Yes ____
Any other condition:	No ____ Yes ____

If YES, to any of the above, please describe: _____
_____

**********PHYSICAL EXAMINATION**********

Are there any abnormalities of:

1. HEENT	Yes ____ No ____	5. Spine	Yes ____ No ____
2. Heart	Yes ____ No ____	6. Extremities	Yes ____ No ____
3. Lungs	Yes ____ No ____	7. Integumentary	Yes ____ No ____
4. Abdomen	Yes ____ No ____	8. Auditory/Vision Screening Results	Yes ____ No ____

HEIGHT: _____WEIGHT: _____ BLOOD PRESSURE: _____/_____ HEART RATE: _____TEMP:_____

REMARKS: _____
_____

****

MEDICAL RATING FOR THE HEALTH SCIENCE STUDENT'S SUITABILITY: A ____ B ____ C _____

A. Suitable for any Nursing/Health Science task.
B. Suitable for any Nursing/Health Science task if _____ is corrected.
C. Suitable for light work or specified tasks such as _____.

HEALTH CARE PROVIDER: _____
Printed Name and Credentials (MD, DO, PA, or CRNP only)

_____ _____
Signature **Date Signed**

Revised 10.16.2024

Student Name: _____
Student "A" No.: _____

BEVILL STATE COMMUNITY COLLEGE
HEALTH SCIENCE DIVISION
IMMUNIZATIONS

Must have proper documentation of all required immunizations by noted deadline or you will not be allowed to attend clinical and will not be able to progress in the nursing program.

*****IF ANY VACCINATION/TITER DATES ARE ADDED TO THIS PAGE AFTER THE DATE THE HEALTHCARE PROVIDER ORIGINALLY SIGNED, YOU MUST HAVE THE ADMINISTERING HEALTHCARE PROVIDER SIGN AND CREDENTIAL THE ADDITION(S).*****

Hepatitis B	Documented Evidence of 3 Hepatitis B vaccinations (2 Heplisav-B vaccines are accepted) **OR** titer indicating laboratory evidence of immunity. If your vaccinations were not given in the correct vaccination schedule (To be compliant with the HepB vaccine requirement, the 2nd dose must be given at least 28 days after the 1st dose. 3rd dose should be given at least 2 months after the 2nd dose or 2 Heplisav-B doses at least 28 days apart) you are **REQUIRED** to get a titer. If your titer is equivocal or negative, you must repeat the vaccination series.

Vaccinations:

1st Hepatitis B (HB) Vaccine: _____
Date

2nd Hepatitis B (HB) Vaccine: _____
Date

3rd Hepatitis B (HB) Vaccine: _____
Date

Repeat Vaccinations (if negative titer):

1st Hepatitis B Vaccine: _____
Date

2nd Hepatitis B Vaccine: _____
Date

3rd Hepatitis B Vaccine: _____
Date

OR Titer:

Hepatitis B Titer: _____ _____
Date Results (Immune or Not Immune)

Varicella (Chicken Pox)	Documented evidence of 2 Varicella vaccinations **OR** titer indicating laboratory evidence of immunity. If your titer is equivocal or negative, you must receive a booster vaccination

Vaccinations:

1st Varicella Vaccine: _____
Date

2nd Varicella Vaccine: _____
Date

Booster Vaccination (if negative titer):

Varicella Booster: _____
Date

OR Titer: Varicella IgG Titer: _____

Date:_____ Results (Immune or Not Immune)

HEALTH CARE PROVIDER: _____
Printed Name and Credentials (MD, DO, PA, or CRNP only)

_____ _____
Signature **Date Signed**

Revised 10.16.2024

Student Name: _____
Student "A" No.: _____

*****IF ANY VACCINATION/TITER DATES ARE ADDED TO THIS PAGE AFTER THE DATE THE HEALTHCARE PROVIDER ORIGINALLY SIGNED, YOU MUST HAVE THE ADMINISTERING HEALTHCARE PROVIDER SIGN AND CREDENTIAL THE ADDITION(S).*****

Measles Mumps Rubella (MMR)	Documented evidence of 2 MMR vaccinations **OR** a positive titer indicating laboratory evidence of immunity to ALL THREE components. If your titer is equivocal or negative, you must receive a booster vaccination

Vaccinations:

1st MMR Vaccine: _____
Date

2nd MMR Vaccine: _____
Date

Booster Vaccination (if negative titer):

MMR Booster: _____
Date

OR Titers:

Measles IgG Titer: _____ _____
Date Results (Immune or Not Immune)

Mumps IgG Titer: _____ _____
Date Results (Immune or Not Immune)

Rubella IgG Titer: _____ _____
Date Results (Immune or Not Immune)

Tetanus, Diphtheria, Pertussis (Tdap)	Documented evidence of 1 Tdap vaccination within the last 10 years. MUST be Tdap; other vaccinations (such as Td or DTap are NOT accepted).

Vaccination:

Tdap: _____
Date

Vaccination: MAY BE REQUIRED BY SOME CLINICAL SITES

1st Meningococcal _____
Date

2nd Meningococcal _____
Date

HEALTH CARE PROVIDER: _____
Printed Name and Credentials (MD, DO, PA, or CRNP only)

_____ _____
Signature **Date Signed**

Revised 10.16.2024

Student Name: _____
Student "A" No.: _____

BEVILL STATE COMMUNITY COLLEGE
HEALTH SCIENCE DIVISION
TUBERCULOSIS TESTING

Admission: You must complete a 2-step TB Skin Test (tests must be at least 1 week, but no greater than 3 weeks apart) OR QuantiFERON-TB Gold blood test **OR** T-SPOT blood test.
Subsequent (after year 1 expires): You must complete 1 TB Skin Test **OR** QuantiFERON-TB Gold blood test **OR** T-SPOT blood test. All tests must be current during the **entire semester for which you are registering**. A one-step skin test **OR** QuantiFERON-TB Gold blood test **OR** T-SPOT blood test is required for returning students who had either a PPD administered or an IGRA Blood test within the past year.

First TB Skin Test

Date Placed: _____ Date Read (within 48-72 hours of placement): _____

Results: Negative: _____ mm
Positive: _____mm

Results read by (printed name and credentials): _____

Signature: _____ Date Signed: _____

Second TB Skin Test

***MUST be placed between 1-3 weeks (7-21 days) after the first test was placed.**

Date Placed: _____ Date Read (within 48-72 hours of placement): _____

Results: Negative: _____ mm
Positive: _____mm

Results read by (printed name and credentials): _____

Signature: _____ Date Signed: _____

QuantiFERON-TB Gold blood test OR T-SPOT blood test

QuantiFERON-TB Gold: _____ _____
Date Results (Positive or Negative)

T-SPOT: _____ _____
Date Results (Positive or Negative)

Results certified by (name and credentials):_____

Signature: _____ Date Signed: _____

****If you have had a positive skin test or blood test, you MUST show proof of a Clear Chest X-Ray. If you show a positive chest x-ray, you must show proof of treatment for TB.**

Bevill State Community College

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Student Name: _____
Student "A" No.: _____

Division of Health Sciences

Influenza Vaccine Record/Waiver/Declination

Influenza vaccine is required for BSCC Health Sciences students, not only to protect themselves, but to reduce the chance of spreading influenza to patients and the community. Influenza can lead to serious complications and be fatal, especially in elderly or sick people, including those who are hospitalized. A person infected with influenza can shed the virus 24 hours before symptoms appear. When infection occurs despite vaccination, it is usually milder. I understand that the information related to my immunization status must be released to any clinical agency to which I am assigned.

RECORD OF IMMUNIZATION

I acknowledge that I have received the influenza vaccine as documented. I will follow any precautions as required by the clinical agencies.
Student Signature: _____
Date Administered: _____ Facility Where Immunization Received_____
Site Administered _____ Manufacturer: _____ Lot No: _____ Expiration Date: _____
Signature of Administering HCP: _____

QUESTIONS	**Yes**	**No**
Have you had a severe (life threatening) allergic reaction to any component of the vaccine including egg protein or to a previous influenza vaccination?		
Do you have a history of allergy to eggs? *If yes, please consult with your physician before receiving the vaccine.*		
Do you have a history of Guillain-Barre syndrome (a severe paralytic illness, also called GBS) that has occurred within 6 weeks of receipt of a prior vaccine? *If yes, please consult with your physician before receiving the vaccine.*		
There is another medical reason:_____		

If you answered yes to any of the questions listed above, proceed to waiver of vaccine section.

WAIVER

Complete if not eligible to receive vaccine
I am not eligible to receive the influenza vaccine today based on the reason(s) marked above. I will comply with clinical agency protocol for those who do not receive the influenza vaccine.

Student Signature: _____ Date: _____

DECLINATION (May be denied clinical placement)

I am eligible to receive the influenza vaccine, **but do not want** to take it. I understand that by refusing the vaccine I may be putting **myself, family, and patients** at risk of getting influenza. I am aware that hospitalized patients are at increased risk of getting serious complications following influenza infection. I will comply with clinical agency protocol for those who do not receive the influenza vaccine.

I am declining receipt of the flu vaccine based on reasons of conscience, including religious beliefs.

Student Signature: _____ Date: _____

Student Name: _____
Student "A" No.: _____

BEVILL STATE COMMUNITY COLLEGE
HEALTH SCIENCE DIVISION
ESSENTIAL FUNCTIONS FOR HEALTH SCIENCE STUDENTS

The Alabama College System endorses the Americans with Disabilities Act. In accordance with the College policy, when requested, reasonable accommodation may be provided for individuals with disabilities. Physical, cognitive, psychomotor, affective and social abilities are required in unique combinations to provide safe and effective care. The applicant/student must be able to meet the essential functions with or without reasonable accommodations throughout the program of learning. Admission, progression and graduation are contingent upon one's ability to demonstrate the essential functions delineated for the health science programs with or without reasonable accommodations. The health science programs and/or its affiliated clinical agencies may identify additional essential functions. The health science programs reserve the right to amend the essential functions as deemed necessary.

In order to be admitted and to progress in the health science programs one must possess a functional level of ability to perform the duties required of a student. Admission or progression may be denied if a student is unable to demonstrate the essential functions with or without reasonable accommodation.

The essential functions delineated are those deemed necessary by the Alabama College System health science programs. No representation regarding industrial standards is implied. Similarly, any reasonable accommodation made will be determined and applied to the respective health science program and may vary from reasonable accommodations made by healthcare employers.

In the interest of student and patient safety, applicants possessing certain limitations may be requested to demonstrate abilities to perform laboratory procedures or skills prior to or after admission to a health science program. Students must be able to demonstrate abilities to perform procedures or skills safely, effectively, and without potential endangerment to the student, faculty, patients or other health care workers. Students must be able to fully participate in the approved program of classroom studies and campus and clinical laboratory learning experience and responsibilities. Medical examination records and/or statements from physicians or other appropriate professional therapists may be required to assist in evaluating a student's ability to fully participate in the learning activities and responsibilities of the Health Science Program. If a student is unable to demonstrate abilities to perform procedures or skills safely, effectively and without potential endangerment the student may be denied admission or progression in a Health Science Program. The Health Science Department will make final determinations regarding an applicant's eligibility for participation in program activities. Technical performance standards and criteria for the Health Science Programs are stated below. Applicants to health science programs must declare if they fully meet the standards and criteria or if they are unable to fully meet them.

Technical Performance Standards and Criteria for Health Science Programs

The essential functions delineated below are necessary for health science program admission, progression and graduation and for the provision of safe and effective care. The essential functions include but are not limited to the ability to:

A. **STUDENT**

Cognitive and critical thinking abilities are sufficient to make clinical judgments and meet laboratory objectives and requirements.

1. Can comprehend new knowledge and apply it in practice.
2. Can analyze situations and identify cause-effect relationships
3. Can organize, problem-solve and make decisions.
4. Can meet mental competency requirements of the Licensing Board.

Student Name: _____
Student "A" No.: _____

5. Can operate a computer after an orientation.

B. **STUDENT**

Interpersonal abilities are sufficient to interact purposefully and effectively with others.

1. Can establish rapport with individuals.
2. Can interchange ideas in a group.
3. Can convey sensitivity, respect, tact and mentally healthy attitude in interpersonal relationships.

C. **STUDENT**

Communication abilities are sufficient to convey thought in verbal and written form so that they are understood by others.

1. Has sufficient English language abilities to understand printed materials, classroom lectures; instructional, medical or other directives; and patient questions and/or responses.
2. Has sufficient English language abilities to be understood in verbal and written communication.
3. Can appropriately use the language of health science program and health care in verbal and written communication.
4. Can teach a concept and test for understanding.

D. **HEALTHCARE PROVIDER/PHYSICIAN**

Physical mobility is sufficient to fulfill classroom, clinical and program objectives safely and effectively. Physical disabilities do not pose a threat to the safety of the student, faculty, patients or other health care workers.

1. Can maintain balance in any position and can stand on both legs, move from room to room and maneuver in small spaces.
2. Can flex and/or abduct and adduct all joints freely.
3. Can achieve certification in cardiopulmonary resuscitation at the professional rescuer level.

E. **HEALTHCARE PROVIDER/PHYSICIAN**

Strength (gross motor skills) and endurance are sufficient to safely fulfill clinical laboratory objectives and requirements.

1. Can stand and walk for 6 hours or more in a clinical laboratory.
2. Can position, lift and transfer patients without injury to patient, self or others.
3. Can push or pull heavy objectives, such as an occupied hospital bed without injury to patient, self, or others.

F. **HEALTHCARE PROVIDER/PHYSICIAN**

Fine motor skills and hand/eye coordination are sufficient to safely fulfill laboratory objectives and requirements.

1. Can manipulate small objects to insert one into another without contamination, such as inserting a sterile needle into a needle cap.
2. Can manipulate objects without extraneous motions, tremors, or jerking.
3. Can write the English language legibly, using correct grammar and syntax.

G. **HEALTHCARE PROVIDER/PHYSICIAN**

Auditory ability is sufficient to communicate effectively with others, to monitor and assess patient status, and to fulfill laboratory objectives and requirements.

1. Can hear and accurately count, describe and discriminate between auscultatory sounds such as those heard when listening to the heart, vessels, lungs, and abdomen.
2. Can hear high and low frequency sounds, such as telephones, monitor alarms, emergency signals, weak cries of infants, and weak calls for help.

Student Name: _____
Student "A" No.: _____

H. **HEALTHCARE PROVIDER/PHYSICIAN**

Visual ability is sufficient to monitor and assess patient status and to fulfill laboratory objectives and requirements. Instruments to enhance or correct vision are portable, usable in small spaces and in varying levels of light, and do not disrupt care or cause discomfort to patients.

1. Can discern the full spectrum of colors and can distinguish color changes.
2. Can accurately read numbers and letters in fine print, such as would appear on medication vials, ampoules, syringes, and monitoring equipment in varying levels of light (daylight to very dim light).
3. Can read for long periods of time.
4. Can read cursive writing, such as would be found in patient's charts.
5. Can detect changes in the environment.

I. **HEALTHCARE PROVIDER/PHYSICIAN**

Tactile ability and sense of smell are sufficient to assess patients and the environment.

1. Can discern tremors and vibrations in various body areas.
2. Can palpate and count pulses.
3. Can discern physical characteristics through touch, such as texture, temperature, shape, size, location, and others.
4. Can smell body and environmental odors, such as infected wounds or burning electrical equipment.

The above statement of criteria is not intended as a complete listing of practice behaviors but is a sampling of the types of abilities needed by the student to meet program objectives and requirements. The Health Science Department, affiliated agencies, or the Licensing Agencies may identify additional critical behaviors/abilities for students. The Health Science Division reserves the right to amend this listing of technical performance standards based on the identification of additional standards or criteria for health science students.

Student Name: _____
Student "A" No.: _____

BEVILL STATE COMMUNITY COLLEGE
HEALTH SCIENCE PROGRAMS
SIGNED ESSENTIAL FUNCTION

Student's Name: _____ Student "A" No: _____

RECOMMENDATION OF HEALTHCARE PROVIDER (PMP): MD, DO, PA OR CRNP

I CERTIFY THAT THE ABOVE-NAMED INDIVIDUAL IS:

_____ Able to perform the stated motor and sensory essential functions.

_____ Unable to perform the stated essential functions. List function number (s) and please explain on the back of this page or on a separate sheet. (____ - ____ - ____ - ____)

_____ _____
Signature – MD/PA/CRNP/DO **Date**

_____
Printed Name **Address** **Phone Number**

I have reviewed the Essential functions for this program, and I certify that to the best of my knowledge I have the ability to perform these functions. I understand that a further evaluation of my ability to perform these functions may be required and conducted by the Health Science Program faculty if deemed necessary to evaluate my ability prior to admission to the program and for retention and progression through the program.

_____ _____
Student Signature **Date**

_____
Printed Name

_____ _____
Address **Phone Number**

_____ _____
City **Zip Code**

Revised 10.16.2024