Butler Community College

Department of Allied Health
HEALTH RECORD

DIRECTIONS: Have your physician fill out and sign the Health Record and fill out the immunizations required.
Turn form in to Instructor first day of class.

Name _____ Birth Date _____
Last First Middle

I. MEDICAL EXAMINATION

Physician check if any abnormal history or physical findings

_____ Cardiovascular System Remarks _____
_____ Respiratory Remarks _____
_____ Gastrointestinal Remarks _____
_____ Genitourinary-Gynecologic Remarks _____
_____ Central Nervous System Remarks _____
_____ Musculo-Skeletal Remarks _____
_____ EENT (include visual & hearing acuity) Remarks _____
_____ Scoliosis Remarks _____

Are there any health conditions which should be called to our attention (including communicable or infectious disease or latex allergies)? _____

The clinical experience for students may require prolonged standing and walking; frequent heavy lifting, pushing, pulling, carrying; occasional climbing, stooping, balancing, kneeling; constant need for good vision and hearing; ability to tolerate stressful situations; and occasional exposure to hazardous material.

List any contra-indications to participation in clinical nursing experiences, taking in consideration the above requirements, and also any health conditions the student may have that would pose a safety concern to residents and staff of the clinical facility or to the student themselves_____
_____

This is to certify that I have examined this student and find that he/she is able to participate in clinical experiences.

Date of examination _____ Examining Physician/NP/PA _____
Address_____
_____

PRE-CLINICAL REQUIREMENTS

II. REQUIRED IMMUNIZATIONS

Tuberculin Skin Test (PPD) or a QFT/TSPOT blood test. A chest x-ray is required for positive reactors to the TB blood test to rule out active TB prior to clinical.

Must be documented by a physician, their office personnel, or a health department representative.

1. 1-STEP TB SKIN TEST

Date planted: _____ Results: _____mm Date read: _____ Read by: _____

OR T-SPOT/QFT Test Date: _____ Results: _____

2. SEASONAL INFLUENZA

Date: _____

3. COVID-19

#1 Date: _____

#2 Date: _____

DOCUMENTATION

I certify I reviewed this student's vaccination record and transcribed it accurately.

Staff Signature_____ Date_____ Name of Agency _____