



NORTHEAST

MISSISSIPPI COMMUNITY COLLEGE

DIVISION OF HEALTH SCIENCES

Division of Health Sciences • 101 Cunningham Blvd • Booneville, Mississippi 38829

Phone (662) 720-7236/(800) 555-2154

NORTHEAST MISSISSIPPI COMMUNITY COLLEGE DIVISION OF HEALTH SCIENCES Medical Examination

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____
(Street, Apt #) (City) (State) (Zip Code)

Student ID: _____ Date of Birth: _____

MEDICAL HISTORY (To be completed by the client/student): Do you presently have or have you ever had a history of any of the following? Please mark either yes or no for each section. Any 'yes' answers **MUST** be described in the comments section.

	YES	NO		YES	NO
1. Heart Disease			13. Lung Disease		
2. Kidney Disease			14. Musculo-Skeletal Disorders		
3. Cancer			15. Childhood Diseases		
4. Hypertension			16. Difficult Pregnancy		
5. Diabetes			17. Allergies		
6. Mental/Emotional Disorder			18. Other Diseases (list)		
7. Neurological Disorder			19. Hospitalizations		
8. Seizures (Epilepsy)			20. Serious Illness		
9. Cognitive Disorder			21. Liver Disorders		
10. Immune Disorder			22. Are you presently under the care of a physician? (<i>explain</i>)		
11. Blood Disorder			23. Lifestyle habits/practices (<i>list</i>) i.e., smoking, alcohol use, etc.		
12. Are you currently receiving any therapy/medication? (<i>list</i>)			24. Vision Problems / Hearing Problems / Speech Problems		

COMMENTS (identify by reference number): _____

I attest the information above is accurate to the best of my ability to determine. I understand that should my health status change on the above listed items (#1-24) while I am enrolled in a health sciences program, I am to report these changes to the Program Director and provide documentation as requested or deemed necessary.

(Signature of Client/Student) (Date)

Name of client: _____ Date of Physical Exam: _____

TO PRIMARY CARE PROVIDER: Each item on the pre-entrance medical form must be completed in order to meet contractual guidelines of affiliating agencies and the health sciences programs. If you do not provide diagnostic services for any of the requested data, please refer the applicant to the appropriate agency. Thank you.

Academic Head, Division of Health Sciences

PHYSICAL EXAMINATION (Must be completed by the PRIMARY CARE PROVIDER);

General State of Health _____

Vital Signs: Temp _____ Pulse _____ Resp _____ B/P _____

Nutritional Status _____

Mental Status _____

Skin _____

Head (and neurologic status) _____

Eyes, Ears, Nose, Throat (describe vision / hearing / teeth) _____

Lungs _____

Heart (rhythm, murmur, rub) _____

Breasts _____

Abdomen _____

Musculoskeletal _____

Genitourinary (please include menstrual history, bowel / bladder problems) _____

Hemoglobin or Hematocrit Test: _____ Date: _____ Results: _____

Statement of Eligibility (to be completed by the Physician / Nurse Practitioner)

Health Sciences/Nursing is “a practice discipline with cognitive, sensory, affective, and psychomotor performance requirements.”
(Southern Council on Collegiate Education for Nursing Task Force)

A person practicing in the health sciences must have intellectual, interpersonal, and communication skills. In addition, certain other abilities are necessary including: (1) emotional stability sufficient to assume responsibility / accountability for actions; (2) fine motor ability sufficient to perform skills such as picking up, grasping, and manipulating small objects with the hands; (3) physical mobility and strength sufficient to move about on a nursing unit and participate in client care (this involves lifting , standing, stooping, pushing); (4) physical stamina sufficient to perform client care for the length of a work shift; (5) auditory ability sufficient for assessment of client health; and (6) visual acuity sufficient to see objects, to read fine print, and to distinguish color.

(National Council of State Boards of Nursing)

Based on this history and physical assessment, it is my opinion that _____ should be able to meet the requirements identified above.

Based on this history and physical assessment, it is my opinion that _____ should be able to meet the requirements identified above with the exception of _____ with the following restriction _____ or recommendations _____

(signature) (title) (date)

(address) (telephone)



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Health Requirements**

Required immunization documentation should be submitted on a State Public Health Form 121, easily accessible to all clinics and health departments.

Physical Examination
<ul style="list-style-type: none"> ○ Print form and have health care provider complete ○ Must include hemoglobin or hematocrit result
Negative drug screen (at least 9 panel)
<p>TB – Must have DOCUMENTATION of 2 TB skin test results OR one QFT result.</p> <p>1. Proof of previous TB skin test (1) AND current TB skin test (2) that will go through May OR</p> <p>2. Two-step test – those who have not had a TB skin test within twelve months. The two-step includes an initial TB skin test (1) with a second TB skin test (2) within 7-21 days OR</p> <p>3. QuantiFERON®-TB Gold Test (QFT) or equivalent test that will go through May. Chest X-ray if TB test is contraindicated with proof of date and results.</p> <p><i>Students with positive TB tests must be further evaluated and follow the recommendations of the Public Health Department.</i></p>
Rubella
<i>(Validate by one of the identified methods. NOTE: the vaccine is contraindicated with pregnancy or conception within 3 months of immunization)</i>
Proof of 2 immunizations
OR
Proof of Positive Rubella Titer
OR
Birth before 1957; Date of Birth
Hepatitis B Vaccine
<i>(Validated by one of the identified methods)</i>
Proof of 3 immunizations <i>(Completed or in process of receiving all 3 at recommended time intervals)</i>
OR
Proof of Positive Hepatitis B Titer
Proof of Tetanus/Diphtheria/Pertussis (TDaP) vaccination since childhood DTaP <i>(usually given AROUND the age of 11-12)</i>
and a tetanus containing vaccine within the last ten years <i>(If Tdap wasn't received in past 8 years, it won't carry you through graduation, so you will be required to receive a Td immunization.)</i>
Varicella (Chicken Pox) <i>(Validated by one of the identified methods)</i>
Documented positive titer,
OR
Documentation of two (2) varicella vaccinations
Influenza-FLU Vaccine <i>(Must submit documentation BY October 1st annually)</i>

Students returning to second year:

- Must submit proof of annual TB skin test that will be in effect until next May.

Students readmitted to a program:

- Same requirements as a new student

****COVID requirements may be necessary prior to attending clinical experiences in local facilities.**

Revised August 2018, August 2019, June 2020.