444 Western Boulevard
Jacksonville, North Carolina 28546-6816
Phone (910) 455-1221

Nursing and Allied Health Programs

Student Medical Form

Student Name: _____

Program: _____

Date: _____

Revised 6/2025

Instructions for Completion of the Student Medical Form

The information provided in this health form by the student and the health care provider is confidential and protected by the Health Insurance Portability and Accountability Act Privacy Rule.

Student Must Complete:

1. The student should complete the immunization requirements and must provide the school with documentation of any immunizations, titers, or screening tests done prior to the current physical exam. Students who are providing titers showing immunity in lieu of a vaccination record must submit the laboratory result documenting the titer.

Provider Must Complete:

2. If new immunizations, blood tests, or screening tests are done during the physical exam visit, the health care provider must document, initial those, and sign the immunization summary.
3. The health care provider must complete and sign the physical exam form.

Additional Requirements for Surgical Tech, Medical Lab Technician, and Dental

- Dental and Surgical tech students require a vision exam including a fundoscopic exam
- Medical lab technician students require a color vision test

Instructions regarding immunizations and health screening tests

In order to protect both you and your patients, our clinical agencies require the following immunizations and health screening tests. In order to attend clinical rotations, you must provide all of the required information unless you have a documented medical contraindication.

Use the following checklist to confirm that you have provided all required information regarding immunizations and health screening tests.

_____ **Measles, mumps, rubella (MMR)**

Unless you were born before 1957, you must provide the following:

- Two MMR vaccinations after your first birthday
  OR
- Titers showing immunity to each of the three disorders

_____ **Varicella**

- Two varicella vaccines
  OR
- Titer showing immunity (Surg Tech will need a Positive titer for clinical requirements).

_____**Tetanus/diphtheria (TD) or adult tetanus/diphtheria/pertussis (Tdap)**

- Td booster every 10 years AND
- One-time dose of Tdap as soon as possible if individual has not received Tdap previously (regardless of when previous dose of Td was received).

_____ **Tuberculosis screening**

- Baseline individual TB Risk Assessment including TB symptoms evaluation AND
- Initial TB/PPD: Two step PPD within 12 months of program start (both tests must be administered and read within 21 days) **OR** a Quantiferon Gold **OR** T-spot blood within 12 months of program start
- Students with a positive TB skin test in the past, due to either TB exposure/infection or BCG vaccination, a chest x-ray within the last 2 years is required along with the Baseline Individual TB Risk Assessment and TB symptom evaluation. (Note: If a PPD is positive, chest x-ray should be negative for TB disease and individual asymptomatic for TB).
- Annual Tuberculosis Risk Assessment and Attestation

_____ **Hepatitis B**

- Energix-B or Recombivax HB three doses series or; HepA-HepB three dose series; if incomplete series then Heplisav-B (2 doses, 4 weeks apart)
  OR
- A titer showing immunity (quantitative results required)
- Since the series and titers take an extended period of time, you may be mid-process when clinicals begin. Provide all documentation that you have. Your Department Head will give you interim instructions.

Influenza

- Influenza immunization is not part of your fall admission requirements, but you will be required to receive the vaccine annually during the flu season unless you have a documented medical contraindication or religious objection. Declination of influenza may result in inability to participate and complete clinical requirements. You will be informed of the appropriate time to receive this vaccination.

COVID-19

- The COVID-19 vaccination is required by clinical sites for participation in clinicals. The following meet requirements:
  - 2 doses of Moderna COVID-19
  - 2 doses of Pfizer Covid-19
  - 1 dose of Janssen Covid-19
  - 2 doses of Novavax Covid-19
  - 1 dose of Moderna or Pfizer Covid-10 Bivalent
  - Communicate with your Department Head regarding religious or medical exemption at least 30 days prior to beginning program

Immunization Record

Name _____

The student should complete the Immunization Record prior to the exam and provide documentation of any prior immunizations, titers, or screening tests to support the previous immunizations.

If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

*Printed results/record with student name and date of birth can be used as an alternate to this form.

Required immunizations

	Date	Date	Date	Date
DTP or Td (Initial series)	___/___/___	___/___/___	___/___/___	___/___/___
Td or Tdap (within past 10 years)	___/___/___			
Tdap	___/___/___			
MMR (2 after 1st birthday) **or titer**	___/___/___	___/___/___		
Varicella (2) **or titer**	___/___/___	___/___/___		
Hepatitis B (initial series) **or titer**	___/___/___	___/___/___	___/___/___	
Hepatitis B (optional 2 to complete series)	___/___/___	___/___/___		
COVID-19 date & type	___/___/___	___/___/___	___/___/___	___/___/__

Titers (where indicated)

	Date	Result
Rubeola (measles)	___/___/___	
Mumps	___/___/___	
Rubella	___/___/___	
Varicella	___/___/___	
Hepatitis B titer #1* (after original series if required)	___/___/___	**mIU/mL***
Hepatits B titer # 2 * (after single booster if required)	___/___/___	**mIU/mL***
	___/___/___	

***A quantitative hepatitis B titer result is required.**

Tuberculosis screening (most recent) ***Either PPD or TB blood testing is acceptable for health occupation students.***

	Date Placed	Date Read	Interpretation
PPD Step 1	___/___/___	___/___/___	
PPD Step 2	___/___/___	___/___/___	
QuantiFERON Gold or T-Spot (pos, neg, or indeterminate)	___/___/___		

OR

Screening following positive PPD history (most recent)

	Date	Result
Chest X-ray (pos or neg)	___/___/___	
Record of TB screening (attach form and indicate low risk or high risk)	___/___/___	

If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

_____ _____

Signature of physician, nurse practitioner, or physician's assistant **Date**

_____

Print Name of Health Care Provider

Physical Examination

Name _____

Height _____ **Weight** _____ **TPR** _____/_____/_____ **BP** _____/_____

	Normal	Abnormal	Description or Comments
Head, ears, nose, throat			
Eyes			
Respiratory system			
Cardiovascular system			
Gastrointestinal system			
Abdomen			
Genitourinary system			
Musculoskeletal system			
Endocrine system			
Neurological system			
Skin			

Are there currently any limits on the student's physical activity? If yes, please provide brief details and timeframe that these restrictions apply:

Please evaluate the student's mental health status as it pertains to their ability to perform in a healthcare training environment, including clinical settings. Clinical environments will involve high-stress situations and direct patient care responsibilities.

1. Mental Health History – Does the student have a known history of any psychiatric or psychological conditions that may impact their ability to safely perform in a clinical or classroom setting?

☐ **Yes** ☐ **No**

If yes, please explain and indicate whether the condition is currently stable and/or under treatment:

2. Current Mental Status – Based on your assessment, does the student appear to be mentally alert, emotionally stable, and capable of exercising good judgement?

☐ **Yes** ☐ **No**

If no, please explain and indicate whether the condition is currently stable and/or under treatment:

3. Clinical Readiness and Mental Health Limitations – Based on your assessment, does the student have mental health limitations that would limit participation in a nursing or allied health program (including direct patient care responsibility)?

☐ **Yes** ☐ **No**

If yes, please explain and indicate whether the condition is currently stable and/or under treatment:

Examiner's statement: Based on my assessment of this student's physical, emotional, and mental health, at this time they appear able to participate in a nursing or allied health program as well as the clinical setting (including director patient care responsibilities) without limitations.
☐ **Yes** ☐ **No**

If no, please provide comments:

_____ _____

Signature of Physician, Nurse Practitioner, or Physician's Assistant **Date**

_____ _____

Print Name of Health Care Provider **Area Code and Phone**

_____

Office Address **City** **State** **Zip Code**