

**RICHMOND COMMUNITY COLLEGE
NURSING SERVICES
ADVISORY COMMITTEE MEETING AGENDA**

Tuesday, April 15, 2014/4:00 p.m./GHSB Rm. 102

Welcome

Dr. Anthony Clarke
Vice President for Instruction/CAO

Introduction of Faculty/Committee Members

Carole Gibson, RN, MSN
Nursing Department Chair

What's New with You/Organization?

Departmental Reports

1. Nursing: Carole Gibson
 - A. Measures of Program Outcomes
 1. Enrollment
 2. Admissions
 3. Pinning
 4. Retention
 5. NCLEX
 6. Employment
 7. Policy Revisions
 8. Quality Improvement
 - a. Linda King: Active Learning Strategies
 - b. Sue Wagner: Capstone Overview
 - c. ATI Live Review
 - B. Partnerships with Universities: Opportunities for BSN
 1. RN to BSN
 2. RIBN
 - C. Student Medical Form
 - D. Information from Employers: Expected New Hires
 - E. Preceptorship 2014
2. Nursing Assistant/WED: Tina Nielsen

RICHMOND COMMUNITY COLLEGE
NURSING ADVISORY COMMITTEE MEETING
Tuesday, April 15, 2014/4:00 p.m./GHSB Rm. 102

ATTENDANCE SHEET

MEMBERS		ATTENDANCE
Dr. Kirk	Hasenmueller	
Allison	Duckworth*	Present
John	Jackson	
Nancy	Caulder	Present
Michael	McNair	
Brenda	Ewing	
Deana	Kearns*	*Sent Representative
Lisa	Dial Hunt	
Rachel	Lampley	
Dr. Cherry	Beasley	
Tammy	Slaughter*	*Sent Representative
Julie	Woody*	*Sent Representative
Leonetta	Wiley	
Paula	Blackburn	
Melissa	Reaves	
Camille	Utter	
Tiz	Garner	Present
Sadie	Cassidy	
Sharon	Goodman	Present
Fina	Nielsen	Present
Chaise	Millen	Present
Trudy	Davis	In scheduled Clinical
GUESTS		ATTENDANCE
Dr. Anthony	Clarke	Present
Jill	Ward	Present* (Representative for Tammy Slaughter)
Gloria	Walters	Present* (Representative for Deana Kearns)
Kristina	Leyden	Present* (Representative for Julie Woody)
Tammy	Brigman	Present* (Came with Allison Duckworth)
RCC FACULTY		ATTENDANCE
Shelia	Adams	Absent (Family/Medical)
Emily	Aycock	Present
Heather	Cox	In scheduled Clinical
Carole	Gibson	Present
Deborah	Goodwin	Absent (Personal Leave)
Crystal	Greene	In scheduled Clinical
Brenda	Huffman	In scheduled Clinical
Linda	King	Present
Kay	Privette	Absent (Family/Medical)
Janet	Sims	Absent (Family/Medical)
Sharonda	Sturm	Present
Judith	Thompson	In scheduled Clinical
Ronnie	Tunstall	Present
Sue	Wagner	Present

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John	Jackson	
Nancy	Caulder	Nancy Caulder
Michael	McNair	
Brenda	Ewing	
Deana	Kearns	Stone waited for Deana Kearns
Lisa	Dial Hunt	
Rachel	Lampley	
Dr. Cherry	Beasley	
Tammy	Slaughter	
Julie	Woody	Kristina Leyden Kristina Leyden
Leonetta	Wiley	
Paula	Blackburn	
Melissa	Reaves	
Camille	Utter	
Tiz	Garner	Tiz Garner
Sadie	Cassidy	
Sharon	Goodman	SHARON GOODMAN
Tina	Nielsen	Dina Nielsen
Chaise	Millen	Chaise Millen
Trudy	Davis	In scheduled Clinical
GUESTS		ATTENDANCE
Jill	Ward	Jill Ward
Dr. Tony	Clarke	Dr. Tony Clarke
Tammy	Brigman	
RCC FACULTY		ATTENDANCE
Shelia	Adams	Absent (Family/Medical) Emily Adams
Emily	Aycock	
Heather	Cox	In scheduled Clinical
Carole	Gibson	Carole Gibson
Deborah	Goodwin	Personal Leave
Crystal	Greene	In scheduled Clinical
Brenda	Huffman	In scheduled Clinical
Linda	King	Linda King
Kay	Privette	- Family Sickness
Janet	Sims	- Family Sickness
Sharonda	Sturm	Sharonda Sturm
Judith	Thompson	In scheduled Clinical
Ronnie	Tunstall	Ronnie Tunstall
Sue	Wagner	Sue Wagner

RICHMOND COMMUNITY COLLEGE
Nursing Services Advisory Committee Meeting Minutes
Tuesday, April 15, 2014/4:00 p.m.

Those in attendance included: The meeting agenda and attendance sheets are attached to the original minutes. The following topics were discussed:

TOPIC	DISCUSSION	FOLLOW-UP
Welcome	Dr. Anthony Clarke, VP for Instruction/CAO, welcomed committee members and thanked them for the service they provide to the college.	
What's New in Your Organization?	Committee members introduced themselves and provided updates from their respective organizations: FirstHealth Moore: Expecting surveyors this week. FirstHealth Richmond: *Have closed their OB Unit *Continue to offer OB Clinic *Radiology renovation *Adding GI doctor	

DEPARTMENTAL REPORTS
NURSING

Carole Gibson, Nursing Department Chair, provided copies of the RCC Mission & Vision Statements, Nursing Vision Statement, Program Outcomes, and Student Learning Outcomes (copies attached to the original minutes). The following topics were discussed:

Measures of Program Outcomes

1. Enrollment:

ADN/1st year: 39/79 (49.4%) *Expect 41 for Fall 2014; 41-79 = 51.9%
ADN/2nd year: 26/85 (30.6%)
PN: 17/20 (85%)

2. Admissions Projected for Fall 2014:

ADN: 81 students have met higher admission standards
PN: 100+ qualified applicants
Nursing Orientation: May 21, 2014
ADN Pre-Nursing: June 16-26, 2014/ Mon.-Thurs.

3. Pinning: ADN= May 8, 2014 PN = July 17, 2014

4. Retention: Monitor retention each semester. Retention continues to be a major focus. Nursing Improvement Plan implemented to improve retention and NCLEX passage rates. Board of Nursing statistics show slight improvement for 2010-2012. Expect retention to improve with implementation of new admission, re-admission, and progression policies.

5. NCLEX/ADN 2013: 66% (19/29)

RCC 3-year average for 2011-2013 = 85%
National 3-year average pass rate = 87%
NC 3-year average pass rate = 83%

NCLEX /PN 2013: 76% (16/21)

19 graduates from 2013; 14 of 18 tested in 2013 and passed = 83%. Three students from 2012 tested, one failed; one student from 2013 tested in 2014. Total of 21 graduates tested for first time in 2013; 16 passed. 16/21= 76%.

RCC 3-year average pass rate: 83%

National 3-year average pass rate: 85%

NC 3-year average pass rate: 81%

6. Employment Statistics:

ADN 2013 Graduates: 27/29 employed = 93% employment (two have passed boards, but unable to obtain employment data). **PN 2013 Graduates:** 12/19 employed = 63.2% employment.

7. Policy Revisions: See Nursing Improvement Plan Summary (copy attached to the original minutes).**8. Quality Improvement/Active Learning Strategies:** Capstone Modules and ATI Live Review (Assessment Technologies Institute). The Nursing Improvement Plan Summary was presented and copies were provided to members (copy attached to the original minutes).**9. Partnerships with Universities/Opportunities for BSN:**

Bridge Program: UNC-P RN to BSN Program: Student can take most of the required non-nursing courses on our campus. Faculty begins advising students regarding need for BSN during orientation. **RIBN:** RCC is a part of the South Central North Carolina Project. Goal is to have 3-4 students enrolled in the Fall of 2014. Dual enrollment with RCC and UNC-P. Targeting high-performing high school students. 3.0 GPA required for Admission, 2.8 GPA required for continued enrollment.

10. Student Medical Form: Requirements were reviewed and agreed on for 2014-2015 (copy attached to the original minutes).**11. Information from Employers Regarding Expected New Hires:** FirstHealth Richmond is planning to hire 2 RN's for ED and 2 RN's for Medical. FirstHealth Moore is expecting to hire 35 new graduates.**12. Preceptorship 2014:** RCC appreciates the opportunity to offer this program for our students. We would like to recognize and say thank you to all RN's who have served as Preceptors.

Ideas from Committee Members: Reception and recognition certificates

CERTIFIED NURSING ASSISTANT/ WED

Tina Nielsen, Allied Health Coordinator for CNA—WED, discussed the following topics:

1. Department is increasing offerings for CNA I—WED classes.
2. Currently offering one day, two evening, and one online hybrid classes. Will add another online hybrid class starting April 27.
3. Spoke about the changes in the NACES office with the resignation of one of the main contacts, Cheryl Anderson, from our point-of-contact list.
4. Mrs. Nielsen stated that she might possibly become an evaluator for CNA state testing (won't be allowed to test RCC students). This will give us an inside look at how state testing is done and how evaluators are taught to test students.

There being no further business, the meeting was adjourned.

Next Meeting: Fall 2014

Recorder: Carole Gibson

**RCC
NURSING DEPARTMENT**



**Program Objectives/
Student Learning Outcomes**

February 2014 Update

Nursing Department: Vision Statement

The Nursing Programs at Richmond Community College will be recognized as a model of excellence in preparing nurses for the 21st century healthcare environment by:

- Recruiting/retaining/developing master's prepared faculty
- Embracing cultural diversity
- Recruit students from top 10-20% of High School students
- Provide education and experience that prepares professional, competent, and caring nurses
- Strengthen simulation opportunities to improve cognitive and technical skills
- Improve retention to meet BON recommendations:
 - Enroll quality students
 - Utilize RN's in the community for tutoring through the Student Success Center
 - Revise admission criteria
 - Provide support services for at-risk students
- Maintain NCLEX scores above the state requirement
- Expand and maintain supportive relationships with clinical agencies
- Use various teaching modalities to address the learning needs of a diverse population
- Use data to drive decision making and continuous improvement
- Provide opportunities for seamless transition to the ADN or BSN Program
- Target enrollment: 125-130 (ADN) & 20 (PN)

NURSING IMPROVEMENT PLAN SUMMARY

Background

- *Significant decline in NCLEX-RN passage rate/Summer 2013
- *Decline in ADN retention
- *Steady decline in NCLEX-PN passage rate

Objectives

1. Attract and admit academically-prepared students
 - A. Revised admission/readmission policies
 1. GPA (A D N & PN)
 - 2.0 GPA based on last 12 hours of college level courses
 - GPA Points for admission: higher GPAs => points
 - Use High school GPA if applicant has not completed 12 hrs of college level courses
 2. TEAS score (A D N)
 - Cut score increased to 58, proficient
 - Added a minimum math requirement of 55
 - Returning students must make 10% above the proficient level, 63 composite score and required math score
 - Currently evaluating use of TEAS for PN applicants.
 - B. Eliminate A10300N, nearly complete, allows Nursing faculty to concentrate on advising current Nursing students; students in the “holding tank” for Nursing are on a path to a degree.
 - C. Improve Pre-Nursing
 - Strengthened math review, (includes early identification of high-risk students. Tutoring is made available to students prior to admission to Nursing); Pre-Nursing modules include: math, time management, study skills, skills modules, learning styles inventory, personality inventory, provide realistic information on the program including professional expectations (includes drug screening, criminal background requirements and use of social media)
 - D. Increase applicant pool
 1. Grow partnerships, includes partnerships with high schools and universities
 2. Media highlights to profile graduate success stories
 3. RIBN (Regionally Increasing Baccalaureate Nurses)
 2. Provide academic support services
 - A. Tutoring
 - B. TEAS Test Prep
 - C. Workshops on test-taking strategies

3. Offer student support to increase student success
 - A. Counseling
 - B. Other workshops designed to meet student needs
4. Improve curriculum and pedagogy
 - A. Modified progression requirements

Students must pass first 8 week session to progress to 2nd 8 weeks
Returning students must pass comprehensive test on courses successfully completed
 - B. Required remediation

Required for students scoring < 80 on unit tests. Student participation has been good (NUR 112, 114). Implemented Facilitated Learning in NUR 114, Spring 2014.
 - C. New products/resources
 1. Scenarios/case studies/practice tests/pharmacology modules/
procured tests used to support student learning
 2. Evaluating options to create the “flipped classroom”
 3. Comprehensive predictor/Capstone modules

Predictor to be administered two times during last semester,
Before and after Capstone Modules
Individual remediation plan is developed based on performance.
1st Comp predictor administered Feb. 26. 10% of grade is
Generated from Capstone performance
 4. Live NCLEX review: built into existing semester, paid over 4 semesters
5. Enhance professional development for Nursing faculty
 - A. Focus on faculty-student interaction
 - B. Maintain and increase scholarly activities through media, professional development and organizations, and ATI Academy.
 1. College has provided opportunities for continuing education related to Creative Teaching Strategies, Concept-Based Teaching/Learning, Generational Learning.

Data collected relating to Nursing student success/ retention support the activities above. Research supports using GPA, admission testing scores, testing returning students as part of the re-admission process,(common practice at nearby schools)



Lillian Duer James School of Nursing Student Health Form

REPORT OF MEDICAL HISTORY

(Please print in black ink)

To be completed by student

LAST NAME (print)	FIRST NAME	MIDDLE/MAIDEN NAME	STUDENT ID# (SID)						
PERMANENT ADDRESS		CITY	STATE	ZIP CODE	AREA CODE/PHONE NUMBER				
DATE OF BIRTH (mo/day/yr)		GENDER	<input type="checkbox"/> M	<input type="checkbox"/> F	MARITAL STATUS	<input type="checkbox"/> S	<input type="checkbox"/> M	<input type="checkbox"/> OTHER	EMAIL _____
CLASS YOU ARE ENTERING (circle): FR. SO. JR. SR. GRAD. PROF.		PREVIOUSLY ENROLLED HERE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATES _____			SEMESTER ENTERING (circle):			FALL	SPRING
		PREVIOUSLY A PATIENT HERE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATES _____			SUMMER 1	SUMMER 2	OTHER	YEAR 20_____	
HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY)					AREA CODE/TELEPHONE NUMBER				
NAME OF POLICY HOLDER					EMPLOYER				
POLICY OR CERTIFICATE NUMBER					IS THIS AN HMO/PPO/MANAGED CARE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO				

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY _____ RELATIONSHIP _____

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

FAMILY & PERSONAL HEALTH HISTORY (Please print in black ink) To be completed by student

Has any person, related by blood, had any of the following:

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol or blood fat disorder				Cancer (type):			
Stroke				Diabetes				Alcohol/drug problems			
Heart attack before age 55				Glaucoma				Psychiatric illness			
Blood or clotting disorder								Suicide			

WEIGHT _____

WEIGHT _____

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year		Yes	No	Year		Yes	No	Year
High blood pressure				Hay fever				Jaundice or hepatitis			
Rheumatic fever				Allergy injection therapy				Rectal disease			
Heart trouble				Arthritis				Severe or recurrent abdominal pain			
Pain or pressure in chest				Concussion				Hernia			
Shortness of breath				Frequent or severe headache				Easy fatigability			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia			
Pneumonia				Severe head injury				Eye trouble besides need glasses			
Chronic cough				Paralysis				Bone, joint, or other deformity			
Head or neck radiation treatments				Disabling depression				Knee problems			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain			
Malaria				Ulcer (duodenal or stomach)				Neck injury			
Thyroid trouble				Intestinal trouble				Back injury			
Diabetes				Pilonidal cyst				Broken bone (specify)			
Serious skin disease				Frequent vomiting				Kidney infection			
Mononucleosis				Gall bladder trouble or gallstones				Bladder infection			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
 Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
 Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____
 Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED (Please print in black ink) To be completed by student

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine			
Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION....PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):

- (A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.
- (B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. (Not applicable to community colleges.)
- (C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. (Not applicable to community colleges.)

nature of Student

Date

Signature of Parent/Guardian, if student under age 18

Date

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (Be certain that your name, date of birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. Keep a copy for your records.)

- High School Records – These may contain some, but not all of your immunization information. Contact Student Services for help if needed. **Your immunization records do not transfer automatically. You must request a copy.**
- Personal Shot Records – Must be verified by a doctor's stamp or signature or by a clinic or health department stamp.
- Local Health Department
- Military Records or WHO (World Health Organization Documents)
- Previous College or University – **Your immunization records do not transfer automatically. You must request a copy.**

SECTION A:	IMMUNIZATION REQUIREMENTS ACCORDING TO AGE				
STUDENTS 17 YEARS OF AGE AND YOUNGER					
DTP or Td ¹ 3	Polio 3	Measles ² 2	Mumps ⁴ 1	Rubella ⁴ 1	
STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER					
DTP or Td ¹ 3	Polio 0	Measles ^{2,3} 2	Mumps ⁴ 1	Rubella ⁴ 1	
STUDENTS BORN BEFORE 1957					
DTP or Td ¹ 3	Polio 0	Measles 0	Mumps 0	Rubella ⁴ 1	
STUDENTS 50 YEARS OF AGE AND OLDER					
DTP or Td ¹ 3	Polio 0	Measles 0	Mumps 0	Rubella 0	
INTERNATIONAL STUDENTS					
Vaccine Required					
Vaccines are required according to age (refer to appropriate box). Additionally, International students are required to have a TB skin test and negative result within the 12 months preceding the first day of classes (chest x-ray required if test is positive).					

1. DTP (Diphtheria, Tetanus, Pertussis), Td (Tetanus, Diphtheria): One Td booster within the last ten years
2. Measles: One dose on or after 12 months of age; second at least 30 days later. Must repeat Rubella (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.
3. Two measles doses if entering college for the first time after July 1, 1994.
4. One dose on or after 12 months of age. Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

SECTION B:	These vaccines are RECOMMENDED. Some may be required by certain departments. Consult your college or department for specific requirements.
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North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Attached to this form is information regarding meningococcal disease, including recommendations from the Centers for Disease Control of the U.S. Public Health Service. Please record on page 6 of this form, whether or not you have received the meningococcal vaccine. If yes, please note the month, day, and year of the vaccination.

SECTION C:	These vaccines are OPTIONAL.
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IMMUNIZATION RECORD		(Please print in black ink) To be completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.		
Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	Student ID# (SID)
SECTION A REQUIRED IMMUNIZATIONS		mo./day/year	mo./day/year	mo./day/year
• DTP or Td		(#1)	(#2)	(#3)
• Td booster <i>(w/in 10 yrs)</i>				
• Polio				
• MMR (after first birthday) <i>(based on age)</i>				
• MR (after first birthday)				
• Measles (after first birthday)				**Disease Date ****Titer Date & Result
• Mumps				*** (Disease Date NOT Accepted) ****Titer Date & Result
• Rubella				*** (Disease Date NOT Accepted) ****Titer Date & Result

SECTION B RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

Meningococcal Received the meningococcal vaccine? No Yes

If Yes, please indicate date(s) vaccine was received (mo./day/year)

	mo./day/year	mo./day/year	mo./day/year	
• Hepatitis B series only OR • Hepatitis A/B combination series	<i>Vaccinated</i>			****Titer Date & Result
- Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
• Tuberculin (PPD) Test (Required annually/) (within 12 months)	Date read mm in duration			
Chest x-ray, if positive PPD	Date Results			
Treatment if applicable	Date			

SECTION C OPTIONAL IMMUNIZATIONS

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner

Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Area Code/Phone Number

Office Address

City

State

Zip Code

Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.

- ** Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

*** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

Do Not Write in This Space

PHYSICAL EXAMINATION

(Please print in black ink) To be completed and signed by physician

or clinic

A physical examination is required by some schools and/or programs (consult your college or department for specific requirements). If required, it must be completed in black ink and signed by a physician or clinic.

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)
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Permanent Address	City	State	Zip Code	Area Code/Phone Number
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Height _____ Weight _____ TPR _____ / _____ / _____ BP _____ / _____

REQUIRED:

Vision: Corrected Right 20/_____ Left 20/_____

Uncorrected Right 20/_____ Left 20/_____

Color Vision (Required) _____

Hearing: (gross) Right _____ Left _____

15 ft. Right _____ Left _____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
° Musculoskeletal			
Metabolic/Endocrine			
1u. Neuropsychiatric			
11. Skin			
12. Mammary			

- A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
Explain _____
- B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
Explain _____
- C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
Explain _____
- D. Is student physically and emotionally healthy? Yes _____ No _____
Explain _____

• Only for Students Admitted to a HEALTH SCIENCES PROGRAM •

Based on my assessment of this student's physical and emotional health on _____, he/she appears able to
(Date)
participate in the activities of a health profession in a clinical setting. Yes _____ No _____ if no, please explain _____

Signature of Physician/Physician Assistant/Nurse Practitioner

Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Area Code/Phone Number

Home Address

City

State

Zip Code

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ADN-PN Health Form—Revised May 2011