



GREENFIELD COMMUNITY COLLEGE
 Health Services
 One College Drive, Greenfield, Massachusetts 01301
 TEL: (413) 775-1430 FAX: 775-1434



HEALTH REQUIREMENTS
Associate Degree Nursing Students

Name	_____	_____	_____	_____
	Last	First	Middle	Date of Birth
Address	_____			_____
	Street	Apt.		Student Number or Social Security Number
	_____			_____
	City	State	Zip Code	
Telephone ()	_____			
	Area Code			
Semester entering:	Fall 20 ____	Spring 20 ____		
Have you previously attended GCC?	No ____	Yes ____	If yes, when _____	
Previous Name(s)	_____			

All Associate Degree Nursing (ADN) students must provide appropriate documentation of immunity as required by the Massachusetts Department of Public Health, Greenfield Community College and clinical sites, **regardless of age or number of credits**. Students must also provide documentation of medical clearance to participate in the ADN program on the Physical Examination form provided.

Students are responsible for providing the Health Service Office with complete health requirement documentation before submitting the ADN Program Application to the Office of Admission.

Exception: Tuberculin Skin Test results are due June 1 – July 15 (see Section VI for specific requirements). Chest X-ray results are required for positive Tuberculin Skin test (see Section VI for CXR requirements).

Return completed health forms to: Greenfield Community College Health Services Office, North Module, Main Campus or mail to GCC Health Services, One College Drive, Greenfield MA 01301. Please call the **Health Service Office, (413) 775-1430**, to check that forms have been received and that information is complete. If you have any questions concerning the health requirements for the ADN Program, please call the Health Services Office.

Prior to application, students are responsible for contacting the GCC Health Services Office for any recent changes in health requirements for this program.

Office use only:
__ IZ
__ PPDx2
__ HX
__ PE
__ PC CONSULT
__ ROI

IMMUNIZATION INFORMATION

Student Name _____
Last First Middle

Date of birth ____/____/____
month day year

Has primary DPT series been completed? _____ # DPT doses: _____ date series completed: ____/____/____

Physician diagnosis or history of disease is not acceptable.	Tetanus-Diphtheria-Pertussis (Tdap) (if last Tetanus Diphtheria (Td) is > 2 years old)	____/____/____ Tdap ____/____/____ Td
	*MMR vaccine #1 **MMR vaccine #2 or serologic proof of immunity:	____/____/____ *must be on or after date of first birthday and must be after 1/1/68 ____/____/____ **must be at least 1 month after the first dose
	Positive Measles Antibody (IgG)	____/____/____ → copy of lab report is required, please attach
	Positive Mumps antibody (IgG)	____/____/____ → copy of lab report is required, please attach
	Positive Rubella antibody (IgG)	____/____/____ → copy of lab report is required, please attach
	Hepatitis B vaccine #1 Hepatitis B vaccine #2 Hepatitis B vaccine #3 or Positive Hepatitis B surface antibody	____/____/____ dose #1 ____/____/____ dose #2 ____/____/____ dose #3 ____/____/____ → copy of lab report is required, please attach
	Positive Varicella antibody or Varicella vaccine #1 Varicella vaccine #2**	____/____/____ → copy of lab report is required, please attach If blood test is negative, two doses of vaccine are required to provide immunity ____/____/____ ____/____/____ **must be at least 1 month after the first dose

Signature of Health Care Provider or Designee is Required:

Signature _____ Date _____

Printed Name _____ Telephone _____

Address _____ Fax _____

HEALTH HISTORY

(To be filled out by the student)

COMPLETE AND BRING THIS HISTORY FORM WITH YOU TO YOUR PHYSICAL EXAM APPOINTMENT FOR REVIEW WITH THE EXAMINING HEALTH CARE PROVIDER

Please check if you have or have ever had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> chicken pox (date: _____) | <input type="checkbox"/> hernia/rupture |
| <input type="checkbox"/> frequent/severe headaches | <input type="checkbox"/> kidney/bladder problems |
| <input type="checkbox"/> seizure disorder/epilepsy | <input type="checkbox"/> unexplained weight loss/gain |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> swollen glands for longer than 2 weeks |
| <input type="checkbox"/> repeated fainting | <input type="checkbox"/> skin disease/disorder |
| <input type="checkbox"/> problems with vision | <input type="checkbox"/> back injury or problems |
| <input type="checkbox"/> problems with hearing | <input type="checkbox"/> numbness or decreased feeling in hands, feet |
| <input type="checkbox"/> asthma | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> frequent cough | <input type="checkbox"/> diabetes or high blood sugar |
| <input type="checkbox"/> exposure to tuberculosis/positive TB test | <input type="checkbox"/> anxiety/depression |
| <input type="checkbox"/> shortness of breath/difficulty breathing | <input type="checkbox"/> mental illness |
| <input type="checkbox"/> chest pain with activity | <input type="checkbox"/> drug/alcohol dependency |
| <input type="checkbox"/> heart disease/condition/murmur | <input type="checkbox"/> hospitalization |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> surgery |
| <input type="checkbox"/> frequent diarrhea | <input type="checkbox"/> latex allergy _____ |
| <input type="checkbox"/> frequent/severe belly pain | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> cancer | <input type="checkbox"/> other _____ |

limited or painful movement or use of:

- | | | | | |
|---------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> neck | <input type="checkbox"/> shoulder(s) | <input type="checkbox"/> elbow(s) | <input type="checkbox"/> wrist(s) | <input type="checkbox"/> hand(s) |
| <input type="checkbox"/> hip(s) | <input type="checkbox"/> knee(s) | <input type="checkbox"/> ankle(s) | <input type="checkbox"/> feet | <input type="checkbox"/> back |

Please explain any items checked: _____

Please list all medications that you currently take: _____

Please list all allergies (food, medication, latex, environmental): _____

BRING THIS HISTORY FORM WITH YOU TO REVIEW WITH THE HEALTH CARE PROVIDER WHO PERFORMS YOUR PHYSICAL EXAM

Have your activities been restricted during the past 5 years?

yes no If yes, please explain: _____

Do you have any condition which might require adaptation of your educational/clinical program?

yes no If yes, please describe: _____

SECTION III

Student statement

- ◆ The health history information given is correct to the best of my knowledge.
- ◆ I agree to notify the Health Services Office regarding any significant change in health status.
- ◆ I understand that all health information received by the Health Services Office is confidential and will not be released by the Health Services without my signed consent.
- ◆ I understand that failure to provide complete health requirements by the deadlines will result in the inability to attend classes. I understand that it is my responsibility to provide all the required documentation and to verify the receipt by the Health Services Office of complete documentation.

Student's Signature

Date

SECTION IV

RELEASE of INFORMATION

I, _____ give Greenfield Community College
Please print name
 Health Services permission to release information regarding immunizations, immunity to infectious diseases, results of Tuberculosis screening and treatment and allergies including latex allergy, to the ADN program coordinator and clinical agencies (e.g. hospitals, long-term care facilities, health centers) for my clinical placements.

Student's Signature

Date

I give Health Services permission to release relevant medical history on a need-to-know basis to the ADN Coordinator if necessary to determine ability to safely participate in the ADN program.

Student's Signature

Date

SECTION V

PHYSICAL EXAMINATION (Bring this form to your Physical Exam)

Physical Exam must be done within one year of starting the program.

To be completed and signed by a physician, nurse practitioner or physician's assistant

A. To the Examining Health Care Provider:

- Successful completion of the **Associate Degree Nursing Program** requires proficiency in the performance of a variety of skills. Technical standards, meant to clarify minimal standards for essential affective and psychomotor functions, require students to:
 - be ambulatory
 - be able to lift a minimum of 50 lbs
 - possess fine motor coordination required to perform such technical skills such as preparation and administration of medications
 - have visual acuity to perform technical skills such as physical assessment, preparation of proper dosage of parenteral medications
 - have auditory perception allowing effective use of stethoscope and communication
 - have emotional stability required to exercise sound judgment and intervention activities
 - have emotional maturity to develop appropriate therapeutic relationships
- Please review student history (SECTION II)** for completeness and provide any additional history here: (This information is strictly for use by the Student Health Service Office and will not be released without the student's written consent.)

B. Physical Examination

Date of Physical Examination / /

Please complete the physical exam form provided, including a summary of active medical problems and recommendations.

Student Name _____ D/O/B / / Age _____

Height _____ Weight _____ BP / / Pulse _____

Vision: Corrected R _____ L _____ Uncorrected R _____ L _____

Hearing: Spoken word _____ Whispered word _____ Tuning fork _____ Audiometry _____
(if available)

	normal	abnormal		normal	abnormal
skin/scars			musculoskeletal:		
HEENT			hands		
neck			wrists		
lymph nodes			elbows		
thorax and lungs			shoulders		
heart			spine		
abdomen			hips		
hernia			knees		
peripheral vascular			ankles		
neurological			feet		
mental status			other:		

Please describe and comment on any abnormal findings:

C. Summary of Medical/Behavioral Problems and Recommendations:

D. Is this applicant capable of full participation in the ADN Program as described by the technical standards in SECTION V, Part A?

yes _____ no _____

Please describe any accommodations needed to meet the technical standards required for participation in the ADN Program:

Are there any further evaluations which should be performed prior to this applicant's participation?

yes _____ no _____

If yes, please explain and give dates for scheduled evaluations:

Results of additional evaluation(s):

____ enclosed

____ to be sent to: Greenfield Community College Health Services
One College Drive
Greenfield MA 01301

E. Signature Required

Signature

____ / ____ / ____
Date

____ / ____ / ____
Date of exam

(must be within one year of start date and updated if any significant change in health since exam)

Name of examining MD, NP or PA (please print)

Address: _____

Telephone: _____

FAX: _____

SECTION VI

Tuberculin Skin Test (PPD/Mantoux)

student name: _____ date of birth: _____

Tuberculosis testing requirements may be completed in one of two ways:

A: 1st PPD between June 1 and July 15
and 2nd PPD two weeks after first.

OR

B: 1st PPD within 1 year, prior to July 15
and 2nd PPD between June 1 and July 15

#1st

Date planted: ____ / ____ / ____
Date read: ____ / ____ / ____
Result: ____ mm induration
*Please do not report as
negative or positive*

#2nd

Date planted: ____ / ____ / ____
Date read: ____ / ____ / ____
Result: ____ mm induration
*Please do not report as
negative or positive*

Test should be done before or on the same day as **MMR** or **Varicella** vaccine administration, or no sooner than 4 weeks after these or any live virus vaccines

CHEST X-RAY: All positive PPDs require a chest x-ray.

X-ray date: ____ / ____ / ____ Results: _____ A copy of x-ray report is required.
____ Report attached ____ Report to be sent (other information: _____)

Signature of Health Care Provider or Designee is required

Signature: _____

Date: _____

Printed Name: _____

Address: _____

Telephone: (_____) _____ - _____