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 ____________________________ Date of Birth ____________________________

Last First Middle

Address ____________________________ Student Number or Social Security Number ____________

Street Apt.

City State Zip Code

Telephone (________) ____________ Area Code ____________________________

Semester entering: Fall 20 _____ Spring 20 _____

Have you previously attended GCC? No ___ Yes ___ If yes, when _______________________

Have you previously applied to any GCC Health Occupation Programs? No ___ Yes ___

Which one? ADN ☐ PNC ☐ PMC ☐ When _______________________

Previous Name(s) ____________________________ Today’s Date ____________

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. Only GCC ADN HX & PE forms are acceptable.

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 checking with the Health Services Office for any recent changes in health requirements for this program.

Revised Feb 2012
<table>
<thead>
<tr>
<th>Immunization Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student Name</strong></td>
<td>______________________________</td>
</tr>
<tr>
<td><strong>Date of birth</strong></td>
<td>____ / ____ / ____</td>
</tr>
<tr>
<td><strong>Last</strong></td>
<td><strong>First</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Immunization Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tetanus-Diphtheria-Pertussis (Tdap) (within the past 10 years)</strong></td>
<td>____ / ____ / ____  Tdap</td>
</tr>
<tr>
<td><strong>MMR vaccine #1</strong></td>
<td>____ / ____ / ____  <em>must be on or after date of first birthday and must be after 1/1/68</em></td>
</tr>
<tr>
<td><strong>MMR vaccine #2 or serologic proof of immunity:</strong></td>
<td>____ / ____ / ____  <strong>must be at least 1 month after the first dose</strong></td>
</tr>
<tr>
<td><strong>Positive Measles Antibody (IgG)</strong></td>
<td>____ / ____ / ____  → copy of lab report is required, please attach</td>
</tr>
<tr>
<td><strong>Positive Mumps antibody (IgG)</strong></td>
<td>____ / ____ / ____  → copy of lab report is required, please attach</td>
</tr>
<tr>
<td><strong>Positive Rubella antibody (IgG)</strong></td>
<td>____ / ____ / ____  → copy of lab report is required, please attach</td>
</tr>
<tr>
<td><strong>Hepatitis B vaccine #1</strong></td>
<td>____ / ____ / ____  dose #1</td>
</tr>
<tr>
<td><strong>Hepatitis B vaccine #2</strong></td>
<td>____ / ____ / ____  dose #2</td>
</tr>
<tr>
<td><strong>Hepatitis B vaccine #3 Or Quantitative</strong></td>
<td>____ / ____ / ____  dose #3</td>
</tr>
<tr>
<td><strong>Positive Hepatitis B surface antibody</strong></td>
<td>____ / ____ / ____  → copy of lab report is required, please attach</td>
</tr>
<tr>
<td><strong>Positive Varicella antibody or Varicella vaccine #1</strong></td>
<td>____ / ____ / ____  If blood test is negative, two doses of vaccine are required to provide immunity</td>
</tr>
<tr>
<td><strong>Varicella vaccine #2</strong></td>
<td>____ / ____ / ____  <strong>must be at least 1 month after the first dose</strong></td>
</tr>
</tbody>
</table>

**Signature of Health Care Provider or Designee is Required:**

Signature________________________________________________________ Date____________________________________

Printed Name________________________________________ Telephone________________________________

Address________________________________________ Fax__________________________

Revised Feb 2012
HISTORY AND PHYSICAL EXAM REQUIREMENTS
Associate Degree Nursing Students

HEALTH HISTORY

NAME________________________________________

DOB________________________________________

(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:

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

limited or painful movement or use of:
___ neck
___ shoulder(s)
___ elbow(s)
___ wrist(s)
___ hand(s)
___ hip(s)
___ knee(s)
___ ankle(s)
___ feet
___ back

Please explain any items checked. Include approximate dates:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please list all medications that you currently take:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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: ____________________________________________________________

STUDENT STATEMENT

━ The health history information given is correct to the best of my knowledge.
━ I agree to notify 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 __________________________

RELEASE of INFORMATION

I, ____________________________, give Greenfield Community College Health Services permission to release information regarding immunizations, immunity to infectious diseases, results of Tuberculosis screening and treatment, and history of 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 __________________________

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

BRING THIS FORM TO YOUR PHYSICAL EXAM between September 1 and Feb deadline.
To be completed and signed by a physician, nurse practitioner or physician’s assistant

A. To the Examining Health Care Provider:

1. 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:
   
   1) be ambulatory    2) be able to lift a minimum of 50 lbs    3) possess fine motor coordination required to perform such technical skills such as preparation and administration of medications    4) have visual acuity to perform technical skills such as physical assessment, preparation of proper dosage of medications    5) have auditory perception allowing effective use of stethoscope and communication    6) have emotional stability required to exercise sound judgment and intervention activities    7) have emotional maturity to develop appropriate therapeutic relationships

2. **PLEASE REVIEW STUDENT HISTORY** 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 ___________________________ DOB _____ / _____ / _____ Age ____________**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BP</th>
<th>Pulse</th>
</tr>
</thead>
</table>

**Vision:** Corrected R _______ L _______ Uncorrected R _______ L _______

**Hearing:** Spoken word _______ Whispered word _______ Tuning fork _______ Audiometry _______

<table>
<thead>
<tr>
<th>skin/scars</th>
<th>normal</th>
<th>abnormal</th>
<th>musculoskeletal:</th>
<th>normal</th>
<th>abnormal</th>
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</thead>
<tbody>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td>hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>neck</td>
<td></td>
<td></td>
<td>wrists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lymph nodes</td>
<td></td>
<td></td>
<td>elbows</td>
<td></td>
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<tr>
<td>thorax and lungs</td>
<td></td>
<td></td>
<td>shoulders</td>
<td></td>
<td></td>
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<td>heart</td>
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<td>abdomen</td>
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<td>hernia</td>
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<td>knees</td>
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<tr>
<td>peripheral vascular</td>
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<td>ankles</td>
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<tr>
<td>neurological</td>
<td></td>
<td></td>
<td>feet</td>
<td></td>
<td></td>
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<tr>
<td>mental status</td>
<td></td>
<td></td>
<td>other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, Part A on page 5?

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: ________________________________
Tuberculin Skin Test (PPD/Mantoux form)

Student name: ___________________________ Date of birth: ______________

Tuberculosis testing may be done in one of two ways:

A: 1st PPD between June 1st and June 28th (In year of entering program)
2nd PPD two weeks after first.

OR

B: 1st PPD Done any time since last July 15th.
2nd PPD After acceptance, between June 1 and July 12th, and at least 2 weeks after the first.

Documentation of both PPD’s must be submitted to the Health Services Office by July 15th

#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: ___________________________ Telephone: (_____)(______)______-
Address: ___________________________ Fax: ___________________________