Southwest Virginia Community College Nursing Program
Student Information, Physical Assessment and Immunization Record Form

Instructions:

- **Student Information** is to be filled out completely by the student
- **Physical Assessment** is to be filled out completely by a physician, physician's assistant or nurse practitioner
- **Immunization Record** is to be filled out by the healthcare provider, signed and dated. Proof of immunization, such as Health Department record or lab result must be attached. **Do Not** leave any item blank. It is the student's responsibility to make sure that the form and documentation are complete

Student Information

Last name: ___________________________________ First name: ________________________________MI: ______

EMPL ID: _________________ Academic Year: ______________ Birth Date(MM/DD/YYYY): _____________________

Mailing Address: ____

VCCS Email: ____

Cell Phone: ______________________________________Home Phone: ____________________________________

By my signature below, I authorize the Southwest Virginia Community College Nursing Program to release the information on this form to clinical agencies as required by clinical affiliation agreements.

Student Printed Name: ____ Date: ________________

Student Signature: ____

Physical Assessment
(to be completed by physician, physician's assistant, or nurse practitioner)

Ht_________ Wt_________ T___________ P__________ R__________ BP___________ Vision__________

Please check in the YES or NO column to indicate status.

Any abnormalities of the following areas?	Yes	No	If yes, Please Explain (include current treatments and medications)
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neurological			
Psychiatric			
Skin			
Lymph Nodes			

Provider Printed Name/Credentials: ____
(MD, DO, NP, PA)

Provider Signature: ____

Provider Phone: ____ Date: ____________________________

<table>
<tr><th colspan="5">Immunization Record</th></tr>
<tr><th>TEST</th><th>RESULT</th><th>DATE</th><th>INITIALS</th><th>NOTES</th></tr>
<tr><td>Two-Step Tuberculin Skin Test (TST) or TB Blood Test or Tuberculosis Symptom Screening Questionnaire and Chest x-ray results</td><td>Documented on Tuberculosis Screening Requirement From</td><td>Documented on Tuberculosis Screening Requirement From</td><td>Documented on Tuberculosis Screening Requirement From</td><td></td></tr>
<tr><th>VACCINE</th><th>DOSE#</th><th>DATE</th><th>INITIALS</th><th>NOTES</th></tr>
<tr><td rowspan="2">MMR (Measles, Mumps, Rubella)</td><td>1</td><td></td><td></td><td rowspan="13">MMR- Documentation of two-dose series of MMR vaccines administered at least 28 days apart OR
2 measles, 2 mumps, and 1 rubella vaccination OR
Lab report of positive MMR IgG antibody titer for all diseases</td></tr>
<tr><td>2</td><td></td><td></td></tr>
<tr><td colspan="4">OR</td></tr>
<tr><td>Individual Shots:
Measles</td><td>1</td><td></td><td></td></tr>
<tr><td></td><td>2</td><td></td><td></td></tr>
<tr><td>Mumps</td><td>1</td><td></td><td></td></tr>
<tr><td></td><td>2</td><td></td><td></td></tr>
<tr><td>Rubella</td><td>1</td><td></td><td></td></tr>
<tr><td colspan="4">OR</td></tr>
<tr><td colspan="4">Attach documentation of titers:</td></tr>
<tr><td>Measles (Rubeola)</td><td>Titer</td><td></td><td></td></tr>
<tr><td>Mumps</td><td>Titer</td><td></td><td></td></tr>
<tr><td>Rubella</td><td>Titer</td><td></td><td></td></tr>
<tr><td colspan="5"></td></tr>
<tr><td rowspan="4">Hepatitis B</td><td>1</td><td></td><td></td><td rowspan="4">Hepatitis B- 3 shot vaccination series OR
Lab report of positive Hepatitis B surface antibody titer</td></tr>
<tr><td>2</td><td></td><td></td></tr>
<tr><td>3</td><td></td><td></td></tr>
<tr><td>Titer</td><td></td><td></td></tr>
<tr><td colspan="5"></td></tr>
<tr><td rowspan="3">Varicella (Chicken Pox)</td><td>1</td><td></td><td></td><td rowspan="3">Varicella- Documentation of two-dose series of Varicella vaccines administered at least 28 days apart OR
Lab report of positive Varicella IgG antibody titer</td></tr>
<tr><td>2</td><td></td><td></td></tr>
<tr><td>Titer</td><td></td><td></td></tr>
<tr><td colspan="5"></td></tr>
<tr><td>Tdap (Tetanus-Diphtheria-Pertussis)</td><td>Tdap</td><td></td><td></td><td rowspan="3">Tdap or Td- Booster from within the last 10 years</td></tr>
<tr><td colspan="4">OR</td></tr>
<tr><td>Td (Tetanus & Diphtheria</td><td>Td</td><td></td><td></td></tr>
<tr><td colspan="5">Clinician Printed Name & Credentials:</td></tr>
<tr><td colspan="5">Clinician Signature:</td></tr>
<tr><td colspan="3">Date:</td><td colspan="2">Phone:</td></tr>
<tr><td colspan="5">Name of Healthcare Facility:</td></tr>
<tr><td colspan="5">Address:</td></tr>
<tr><td colspan="5">Additional Comments:</td></tr>
</table>