**Health Clearance Guidelines**

* Upon admission into a nursing program at WCCS all students must submit and maintain current

health clearance status throughout the length of the program.

* A physical examination must be performed by an MD/Nurse Practitioner with results placed on WCCS Health Science Program physical examination form.
* Current original immunization record (BLUE CARD) or official physician statement on official letterhead which includes proof of immunization for:

Diphtheria

Pertussis

Measles

Mumps

Rubella

Varicella (***(can be listed as having chicken pox in the past instead of an immunization).***

PPD

Tetanus

Hepatitis B vaccination forms and medical liability release form must also be submitted.

***Failure to complete these requirements by the designated date will result in suspension from the program; for failure to meet clinical requirements.* If you have previously been enrolled in another program, you must submit health clearance information.**

**NOTE: The use of “white-out or other correction fluid is not acceptable on this document.**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY NUMBER\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1.** Tuberculin Skin Test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Date***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Results*  *Name of Test***

***Within (1) month prior to the first day of class). If positive, a chest x-ray and reports are required.***

**2. Vision:** Normal acuity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acuity deficit (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Wears glasses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contacts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.** **Hearing**: Normal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deficit (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Uses hearing aids:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.** Are there any known emotional problems that would affect progress in the nursing program or participation in clinical nursing activities?

No Yes if so, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.** Are there allergies that could be exacerbated by the clinical environment or activities?

No Yes if so, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Physical Examination** (*Comment on each abnormal checked in space provided)*

Skin……………………….……………….Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head, Face, Neck ……….…….….Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nose & Sinuses.…………………….Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mouth & Throat..…………………..Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lung & Chest...........................Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart……………………………………..Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vascular System………………….. Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abdomen……………………………….Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Endocrine System…….……………Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spine…………………. …………………Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurologic……………………………..Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision ………………..………………….Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing…………………….……………Normal Abnormal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temp\_\_\_\_\_\_\_\_\_BP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pulse\_\_\_\_\_\_\_\_\_\_Resp\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7.** List any illness or conditions that require regular treatment or alteration in manner of living\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8.** Is this person under a doctor’s care for any physical or mental condition? No Yes if so, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9.** Is this person taking medication for any physical or mental condition at this time?

No Yes If yes, list medication/and dosage/s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10.** Is this person able to function at a level to provide, safety to him/herself and the client on this dosage and type of medicationNo Yes

**11. Immunizations:** Applicants must submit a current immunization record (BLUE CARD) verifying updated PPD and Tetanus booster.

a. Date of last Tetanus (DPI) or (DT) booster\_\_\_\_\_\_\_\_ (tetanus booster within the past 10 years is required.)

b. Measles & Rubella Vaccine Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR Titer: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Is there a history of having chicken pox? No If no, complete varicella vaccines

Yes If yes, skip to # 11

Varicella (Chicken Pox) vaccine Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12.** Is this person pregnant? No Yes

If yes, EDC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13.** Has this person initiated the Hepatitis B series? Has this person completed the Hepatitis B No Yes series? No Yes

Dates (1)\_\_\_\_\_\_\_\_\_\_\_\_\_

(2)\_\_\_\_\_\_\_\_\_\_\_\_\_

(3)\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENTS: PLEASE NOTE**

Whether or not you have initiated or received the series, you MUST attend the scheduled in-service on

bloodborne pathogens during your semester of enrollment in the nursing program. Following the in-

service, you will be required to either: (1) obtain the vaccine (2) refuse the vaccine, or (3) present

documentation of initiation or completion of the series. Appropriate documentation of immunization

status will be kept on file in the nursing department. Students who are pregnant or lactating should

postpone Hepatitis B Vaccination until completion of the pregnancy or lactation.

I certify that as of this date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I have examined\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and found this person

to be free of communicable diseases and physically able to carry out nursing functions in a clinical setting.

*Physician :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Print Physician Name Clearly:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**No*te: The School of Nursing requires that the physician include a tuberculin skin test or chest x-ray. The School of Nursing should be notified if finding represent a hazard with whom the client would come in contact with. Providing any false information will be grounds for denial of admission to the program or grounds for dismissal.***

Physi form main jump dept fol Formulated 1983 Revised 2000,2006,2011,2016