Hinds Community College  
Nursing and Allied Health Programs  
Health Record Packet

All Clinical Requirements (including the NAH Health Record Packet) must be submitted by the health profession program’s designated date. For students admitted to a new program, failure to submit the clinical health requirements on the due date will result in loss of placement. For students who are continuing in a program, failure to submit clinical health requirements on the due date will result in disruption in progression. Attendance guidelines will be enforced.

For questions or information about the Health Record Packet, contact: Jan Muse, Clinical Records Clerk  
601.376.4806  
janice.muse@hindscce.edu

For questions about program deadline dates or satisfactory completion of requirements, contact program representative listed on last page of this packet.

Jan Muse, Room 6  
Student Services Office, Anderson Hall  
Nursing/Allied Health Center  
1750 Chadwick Drive, Jackson, MS

Revised October 2014
<table>
<thead>
<tr>
<th>Clinical Record Requirements</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Completed Health History</strong></td>
<td>✓</td>
</tr>
<tr>
<td>(Page 4, which you will complete)</td>
<td></td>
</tr>
<tr>
<td><strong>Completed Physical Exam Form</strong></td>
<td></td>
</tr>
<tr>
<td>(Page 5, which will be completed by physician or certified nurse practitioner within ninety days prior to the published due date. All areas must be completed.)</td>
<td></td>
</tr>
<tr>
<td><strong>CPR</strong></td>
<td></td>
</tr>
<tr>
<td>Proof of current American Heart Association Health Care Provider Certification with a signed card (front and back). A signed letter will be accepted until the card is available.</td>
<td></td>
</tr>
<tr>
<td><strong>Background Records Check</strong></td>
<td></td>
</tr>
<tr>
<td>(Must submit an original clearance letter from a Mississippi Clinical Agency and the Mississippi State Department of Health.) For more information, review the procedure in the NAH Student Manual on the Health Related Professions page of the College website: <a href="http://www.hindsc.edu/Departments/health_related_professions/default.aspx">http://www.hindsc.edu/Departments/health_related_professions/default.aspx</a></td>
<td></td>
</tr>
<tr>
<td><em>Copy of Lab work for Varicella Titer or Copy of immunization record verifying proof of two Varicella immunizations.</em></td>
<td></td>
</tr>
<tr>
<td>An IGG Varicella titer is required (if there is no proof of Varicella immunizations) and must be completed by the program deadline. Vaccinations are required if the Varicella titer is negative. <strong>Note:</strong> There is a waiting period of at least thirty days between the two injections. There must be at least fourteen days between the last injection and the first day of clinical.</td>
<td></td>
</tr>
<tr>
<td><em>Copy of TB skin test, chest x-ray (CXR) or IGRA</em></td>
<td></td>
</tr>
<tr>
<td>Annually, a record of negative results from TB skin test, CXR or IGRA is required for the duration of the program. <strong>Note:</strong> The CDC recommends a two-step TB skin test initially for all health care providers.</td>
<td></td>
</tr>
<tr>
<td><em>Tetanus (1)</em></td>
<td></td>
</tr>
<tr>
<td>(Proof of one immunization in the past ten years, may use TD, Tdap or DTap)</td>
<td></td>
</tr>
<tr>
<td><em>MMR (2)</em></td>
<td></td>
</tr>
<tr>
<td>(Two MMR’s or proof of a positive titer for each of the following: measles, mumps and rubella. If born before 1957, only 1 injection is required.)</td>
<td></td>
</tr>
<tr>
<td><em>Hepatitis B Immunization/Immunity</em></td>
<td></td>
</tr>
<tr>
<td>A complete series* of three scheduled immunizations is strongly recommended for all programs. A positive Hepatitis B titer can be substituted for a complete series. <strong>Note:</strong> Students are required to have one of the following: a complete series, a positive titer, or a signed declination statement. Students will be required to sign a Hepatitis statement following required OSHA training.</td>
<td></td>
</tr>
<tr>
<td><em>Flu Vaccine</em></td>
<td></td>
</tr>
<tr>
<td>Flu vaccines are strongly recommended. Although no clinical agency currently requires flu vaccines, some agencies may exclude students who are not vaccinated and/or require them to wear a mask for an entire clinical experience.</td>
<td></td>
</tr>
</tbody>
</table>

*Submit copies of appropriate lab work, TB test, Chest X-ray or IGRA, immunizations, and CPR Card.*
The following are requirements for all students entering a health professions programs:

1. A health history completed by the student .................................................. (Page 4)

2. A physical examination by a physician or certified nurse practitioner within three (3) months ... (Page 5) prior to the first class, unless the program has published another deadline. (Must use approved form).

3. Results from the following Clinical Tests*
   - A positive IgG Varicella Titer or documentation of appropriate vaccinations. (Note: two vaccinations are required, see page 6 of this document.)
   - A current (within the past year) negative TB Skin Test, chest X-ray (with negative results recorded) or negative IGRA

   *Note: If clinical test results are reported out of the normal range, Hinds Community College has the option to require that the out-of-range test be repeated and/or require physician follow-up at student expense.

4. A complete Immunization Record

Annually thereafter, students are required to complete the following:

1. A revised health history ............................................................ (Page 4)
2. A physical examination by a physician or certified nurse practitioner ........................................... (Page 5)
3. Clinical Tests: A negative TB Skin Test, chest X-ray (with negative results recorded) or negative IGRA

Facts to Remember about All Immunizations:

1. If a student is pregnant or breast feeding, immunizations may be deferred with written documentation from a physician.
2. If immunizations cannot be taken, such as for allergies, written documentation must be provided by a physician.
3. The clinical agencies may reserve the right to deny the student clinical experiences based on their policies pertaining to no. 1 and 2.
4. MMR and TB skin test can be initiated on the same day but a 30 day waiting period is required if the TB is requested after the administration of the MMR.
5. There is a waiting period of at least 30 days between the two Varicella injections. There must be at least 14 days between the last injection and the first clinical day.

Please note HIPPA regulations prevent sending confidential information to an unsecured fax machine. Student information will need to be mailed or hand-delivered to Jan Muse at the address provided above, on or before the deadline date.
# Hinds Community College
## Nursing and Allied Health Programs

**1750 Chadwick Drive**  
**Jackson, MS 39204**  
**Health History**

Name of Student:  
(Print) Last  
First  
Middle  
SS# or ID#  
Choose one:  
New Student  
Returning Student  
Date of Birth:  
Phone:  
Cell Phone:  
Email:  
Current Address:  
City  
State/Zip  
Emergency Contact:  
Phone:  

1. **Have you ever had or do you now have the following:** (Please check at left of each item) If you check "Yes", please comment below about previous/current treatment.

<table>
<thead>
<tr>
<th>Yes No</th>
<th>Yes No</th>
<th>Yes No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ Chicken Pox</td>
<td>☐ ☐ Tooth or Gum Problems</td>
<td>☐ ☐ Ulcer</td>
</tr>
<tr>
<td>☐ ☐ Diphtheria</td>
<td>☐ ☐ Hay Fever</td>
<td>☐ ☐ Digestive Disturbances</td>
</tr>
<tr>
<td>☐ ☐ Rheumatic Fever</td>
<td>☐ ☐ Asthma</td>
<td>☐ ☐ Hernia</td>
</tr>
<tr>
<td>☐ ☐ Mumps or Measles</td>
<td>☐ ☐ Tuberculosis</td>
<td>☐ ☐ Kidney or Bladder Problems</td>
</tr>
<tr>
<td>☐ ☐ German Measles</td>
<td>☐ ☐ Chronic Cough</td>
<td>☐ ☐ Back Problems</td>
</tr>
<tr>
<td>☐ ☐ Swollen/Painful Joints</td>
<td>☐ ☐ Shortness of Breath</td>
<td>☐ ☐ Arthritis</td>
</tr>
<tr>
<td>☐ ☐ History of Mental Disorders</td>
<td>☐ ☐ Menstrual Disorders</td>
<td>☐ ☐ Foot Problems</td>
</tr>
<tr>
<td>☐ ☐ Epilepsy / Seizure Disorders</td>
<td>☐ ☐ Chest Pain</td>
<td>☐ ☐ Diabetes</td>
</tr>
<tr>
<td>☐ ☐ Frequent Severe Headaches</td>
<td>☐ ☐ Heart Disease</td>
<td>☐ ☐ Speech Difficulties</td>
</tr>
<tr>
<td>☐ ☐ Eye Problems</td>
<td>☐ ☐ High Blood Pressure</td>
<td>☐ ☐ Hearing Difficulties</td>
</tr>
<tr>
<td>☐ ☐ Glasses/Contact Lenses</td>
<td>☐ ☐ Varicose Veins</td>
<td>☐ ☐ Skin Disorders</td>
</tr>
<tr>
<td>☐ ☐ Ear/Nose/Throat Problems</td>
<td>☐ ☐ Excessive Bleeding</td>
<td>☐ ☐ Venereal Disease</td>
</tr>
<tr>
<td>☐ ☐ Hearing Aids</td>
<td>☐ ☐ Jaundice</td>
<td>☐ ☐ Excessive Weight Loss</td>
</tr>
</tbody>
</table>

Comments:  

________________________________________________________________________________

________________________________________________________________________________

2. **Allergies (Food, medication, Latex, etc.)**  
3. **Current Medications:**  
4. **Drug or Alcohol Rehabilitation:**  
5. **Surgical Operations:**  

6. **Accidents or Injuries:**  
7. **Other Health Problems:**  

I certify that I have reviewed the information recorded and that it is true and complete to the best of my knowledge.

Date:  
Signed:  

For questions or information, contact Clinical Records Clerk at 601.376.4806  
HCC- NAH Health Record Packet, p. 4
To be completed by a physician or certified nurse practitioner

<table>
<thead>
<tr>
<th>Vital Signs:</th>
<th>B/P ______</th>
<th>PR ______</th>
<th>Height ______</th>
<th>Weight ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td>Neck / Head</td>
<td>Peripheral Vascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Chest</td>
<td>Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual Acuity</td>
<td>Lungs</td>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td>Heart</td>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auditory Acuity</td>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose/Throat</td>
<td>Nutritional Status</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Current Treatment
________________________________________________________________________
________________________________________________________________________
Remarks / Special Recommendations
________________________________________________________________________
________________________________________________________________________
Print Physician's/Nurse Practitioner’s Name
________________________________________________________________________
Print Physician’s/Nurse Practitioner’s Address
________________________________________________________________________
Physician’s/Nurse Practitioner’s Address Phone
________________________________________________________________________

In your opinion, is there any health problem or prescribed medication which would interfere with this individual’s ability to pursue a program of study that requires classroom and clinical experiences, including physical activity? No Yes (Explain)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Signed

Physician or Nurse Practitioner

Date

For questions or information, contact Clinical Records Clerk at 601.376.4806  HCC- NAH Health Record Packet, p. 5