



Hinds Community College Nursing and Allied Health Programs Health Record Packet

All Clinical Requirements (including the NAH Health Record Packet) must be completed by the health profession program's designated date. Students who have not met requirements will not be allowed to begin or progress in theory, laboratory, or clinical courses. 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, contact:
Nora Butts, Clinical Records Clerk
601.376.4806**

Nora Butts, Clinical Records Clerk, 601.376.4806

**Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204**

STUDENT HEALTH RECORD INSTRUCTIONS

1. A complete health history completed by the student..... Page3
2. A physical examination by a physician/certified nurse practitioner (CNP)..... Page4
within three (3) months prior to the first class. (Must use approved form.)
3. Results from the following Clinical Tests..... Page5
 - A negative **Seven** Panel Custody Urine Drug Screen within three (3) months prior to the first class.
 - A positive IgG Varicella Titer or documentation of appropriate vaccinations. (Note: two vaccination are required, see page 6 of this document.)
 - A current annual negative TB Skin Test or chest X-ray (with negative results recorded)
4. **Complete** Immunization Record..... Page 6

Annually thereafter, students are required to complete the following:

1. A physical examination by a physician or certified nurse practitioner—(page 4 of this packet)
2. Clinical Tests:
 - ▶ Negative TB Skin Test or chest X-ray (with negative results recorded)

Note: If clinical test results are reported out the normal range (for example, abnormal drug screen results), 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.

If you have been out of the program for one or more semesters, you must have a repeat negative Custody Drug Screen within three (3) months prior to re-entering the program.

Please note HIPPA regulations prevent sending confidential information to an unsecured fax machine. Student information will need to be mailed or hand-delivered to Nora Butts at above address on or before the deadline date.

Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204

Program: _____ Campus _____ SS# or ID# _____

Name of Student: _____
(Print) Last First Middle

Birthdate: _____ Phone: _____ Cell Phone: _____

Email: _____

Permanent Address: _____ City _____ State/Zip _____

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.

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

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 following information supplied by me and that it is true and complete to the best of my knowledge.

Date: _____ Signed: _____

Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204
Physical Exam Form
Nora Butts, Clinical Records Clerk, 601.376.4806

Student Name: _____ SS#/ID#: _____ Program: _____ Campus: _____

To be completed by a physician or certified nurse practitioner

Vital Signs:	B/P _____ PR _____	Height _____ Weight _____
General Appearance	Neck / Head	Nutritional Status
Eyes	Chest	Peripheral Vascular
Visual Acuity	Lungs	Musculoskeletal
Ears	Heart	Neurological
Auditory Acuity	Abdomen	Skin
Nose/Throat	Breasts - Axillae	

Current Treatment _____

Remarks / Special Recommendations _____

Print Physician's/Nurse Practitioner's Name _____

Print Physician's/Nurse Practitioner's Address _____

Phone _____

<p>In your opinion, is there any health problem which would interfere with this individual's ability to pursue a program of study and/or a career in a health related profession? ___ No ___ Yes (Explain)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Signed _____ Physician or Certified Nurse Practitioner</p> <p>Date _____</p>
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**Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204
Clinical Tests**

Student Name: _____ SS#/ID#: _____ Program: _____ Campus: _____

1. An IgG Varicella titer is required (if there is no proof of varicella immunizations) and must be completed prior to the first day of class. Vaccination is required if the varicella titer is negative. (Note: 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.) Varicella titer results may be recorded on this form or sent directly to the address below.

ATTENTION: Nora Butts/Clinical Records Clerk

Hinds Community College
Nursing / Allied Health Center
1750 Chadwick Drive
Jackson, MS 39204

Date _____ Results _____

Signed _____ Physician or Nurse
Date _____

2. Custody (**Seven Panel**) Urine Drug Screen - This test must be completed within three (3) months prior to the first class, as part of the student's physical. This result must be MAILED (**not faxed**) directly to the address below.

Attention: Nora Butts/Clinical Records Clerk

Hinds Community College
Nursing / Allied Health Center
1750 Chadwick Drive
Jackson, MS 39204

Specimen must be collected in the presence of and remain in possession of an authorized person, with the report returned directly to the Nursing/Allied Health Center. Urine Specimen must meet minimum specific gravity requirements of testing lab or repeat testing will be required.

Date Collected: _____ Collecting Agency: _____

3. Annually a record of current negative TB skin test or CXR with negative results is required for the duration of the program. Note: for students who are over the age of 45 and have not had a TB skin test for consecutive years, a two step test will be required. If they have had consecutive tests done yearly, then a one step is required.

TB Skin Test: Date administered (1) _____ Date administered (2) _____
Date results read _____ Results _____ Date results read _____ Results _____

OR Chest X-ray: Date _____ Results _____

Signed _____ Physician or Nurse	Note: TB Skin Test must be read within 48-72 hours (2-3 days) after administered.
Date _____	

Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204
 Immunization Record

Student Name: _____ SS#/ID#: _____ Program: _____ Campus: _____

The following immunizations are required as designated by program requirements. Immunizations must be current and certified by the physician or health department.

- | | Date |
|---|----------------------------------|
| 1. Diphtheria, Tetanus, Pertussis
Note: Proof of one dose of Td (DTap) in the past 10 years or one dose of Tdap is required. | _____ |
| 2. MMR - Mumps, Measles (Rubeola), Rubella (German Measles) or proof of a positive titer for each of the following: measles, mumps, rubella
Note: If born before 1957, only 1 injection is required. If born during or after 1957, two injections are required.
Note: 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. | #1 _____
#2 _____ |
| 3. Varicella immunizations or proof of a positive varicella titer is required.
Note: Two injections are required if there is no proof of a positive titer. (Documentation of positive titer can be recorded on page 5.)
Note: 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. | #1 _____
#2 _____ |
| 4. Hepatitis B Immunization – a complete series* of three scheduled immunizations or a signed declination statement is required.
*Series required for Emergency Medical Technology, Surgical Technology, Diagnostic Medical Sonography, and Radiologic Technology programs.
Hepatitis B Immunization is strongly recommended for all other programs. | #1 _____
#2 _____
#3 _____ |

Note: A student may refuse the Hepatitis B immunization unless it is required by the program in which they are enrolled. If it is refused, a declination statement must be signed by the student and placed in his/her file (see form on page 7). If the series has been initiated, but is incomplete, the student must sign an incomplete series statement (see form on page 7).

FACTS TO REMEMBER ABOUT ALL IMMUNIZATIONS

1. If a student is pregnant or breast feeding, immunizations may be deferred with written documentation of the physician.
2. If immunizations can not 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.

Signed	
	Physician or Nurse
Date	

Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204
Sources for Health Requirements*

VERY IMPORTANT - PLEASE TAKE YOUR HCC HEALTH FORM WITH YOU

IMMUNIZATIONS AND SKIN TEST ONLY

- County Health Department (Check phone book for health department nearest you)

PHYSICAL EXAMS/LAB/IMMUNIZATIONS/TB SKIN TEST

- Personal family physician or certified nurse practitioner
- Baptist Medical Clinics
- CheckUps Medical Clinics in Wal-Mart (Information posted in Student Lounge)
- MEA Clinics (Information posted in Student Lounge)
- Family Health Care Clinic in Brandon
- Jackson Comprehensive Health Center
- MedScreens, Inc. (Information posted in Student Lounge)

**Any lab, clinic, or doctor may be used to complete your health requirements. The above list is just a sample to help you find sources for these requirements.*