



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. 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
nrbutts@hindsc.edu**

**Nora Butts, Room 1
Student Services Office, Anderson Hall
Nursing/Allied Health Center
1750 Chadwick Drive, Jackson, MS**

Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
Jackson, MS 39204
Quick Check-List

Name:	ID Number:	
Clinical Record Requirements		✓
Completed Health History (Page 4, which you will complete)		
Completed Physical Exam Form (Page 5, which will be completed by physician or certified nurse practitioner within ninety days prior to the first day of class, unless program has published another deadline.)		
*Copy of Lab work for Varicella Titer or Copy of immunization record verifying proof of two Varicella immunizations. (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, unless the program has published another deadline. Vaccinations are required if the Varicella titer is negative. Note: 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.)		
*Copy of TB skin test or chest x-ray (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 over the age of forty five 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 sufficient.)		
*Tetanus (1) (Proof of one immunization in the past ten years, may use TD, Tdap or DTap)		
*MMR (2) (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.)		
Hepatitis B Immunization (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.) Note: Students are required to have one of the following: a complete series, a positive titer, or a signed declination statement (declination statements will be completed after program begins).		
CPR (Proof of current American Heart Association Health Care Provider Certification. This can include a signed card or a signed letter.)		
Background Records Check (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: http://www.hindscc.edu/Departments/health_related_professions/default.aspx		

*Attach copies of appropriate lab work, TB test or Chest X-ray, immunizations, CPR Card.

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

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 or chest X-ray (with negative results recorded)
- *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:
 - Negative TB Skin Test or chest X-ray (with negative results recorded)

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 Nora Butts at the address provided above, on or before the deadline date.

Hinds Community College
Nursing and Allied Health Programs
1750 Chadwick Drive
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Health History

Name of Student: _____
 (Print) Last First Middle
 SS# or ID# _____
 Birthdates: _____ 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.

- | 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
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1750 Chadwick Drive
Jackson, MS 39204
Physical Exam Form**

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	Peripheral Vascular				
Eyes	Chest	Musculoskeletal				
Visual Acuity	Lungs	Neurological				
Ears	Heart	Skin				
Auditory Acuity	Abdomen					
Nose/Throat	Nutritional Status					

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 _____

<p>In your opinion, is there any health problem 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)</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Signed _____ Physician or Nurse Practitioner</p> <p>Date _____</p>
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