

**CHARITY SCHOOL OF NURSING
DELGADO COMMUNITY COLLEGE**

Health Forms for Admission to the ADN Program

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**The student must submit all the required forms for admission to the program.
Students can mail the forms to:**

**Charity School of Nursing
Office 619
450 South Claiborne
N. O., LA 70112**

**DELGADO COMMUNITY COLLEGE
CHARITY SCHOOL OF NURSING
450 South Claiborne Avenue
New Orleans, Louisiana 70112**

PART A

You are required to have a pre-entrance physical examination within **1 year** of entry into the program. Please have your Healthcare Provider complete **part B** of the forms. Students who do not attend the program for 2 academic semesters must submit a new history and physical.

Course You Are Entering (circle one) Basics NAC I PCN MH NAC II Transition

PART A - To be completed by the student. (Contact information)

DCC Student Identification Number: _____ (If not a DCC student use social security #)

Student Name: _____
Last First Middle/Maiden

Permanent Address: _____
Street City State Zip

E-Mail Address: _____

Mailing Address: (if different from above) _____
Street City State Zip

Phone: Home () _____ Work () _____ Cell() _____

In Case of Emergency: _____
Name Relationship

Address City State Zip

Phone Number (including area code)

My signature below indicates that I have no injury or illness other than those specified on the health forms (Part B). If my condition changes it is my responsibility to notify the nursing department of the change. I understand that falsification, omission or misrepresentation of my physical health and abilities will be grounds for dismissal from the nursing program.

Student Signature

Date

PART B – To Be Completed by the Healthcare Provider (MD, PA or APRN)

This person will be a student at Delgado-Charity School of Nursing, the following immunizations are required. A pre-entrance physical is required within 1 year of entry into the program.

Student's Name: _____

Immunizations **Date Completed**

Tetanus Diphtheria (Td) or Tetanus, Diphtheria, Pertussis (Tdap) _____
(within last 10 years)

Varicella Titer. **Attach titer result.** _____
If the titer result is not positive, vaccination is required.

Rubeola, Mumps, Rubella (MMR)-Titers. **Attach titer results.** If _____
the titers are not positive, vaccination is required.

Meningococcal Vaccine. Can decline but must sign waiver. _____
See page 6.

HBV * 3 injections. Sign waiver if unable to complete series. _____
See page 5, attachment A.

Students who are unable to verify immunity for Varicella and MMR will not meet the health requirements for placement in clinical agencies and admission to the program.

VDRL or RPR Date completed _____ Results _____

Tuberculosis Screening

*For fall admission, have TB test done in early May. For spring admission, have the TB test done in early December. Students not tested with the last year are required to complete the two step Tuberculin skin test process to confirm non-reactive status. Students with a negative PPD must have a second PPD in 3 weeks. Two step skin testing is required only for the initial TB screening. If annual screenings have been done, submit the results for the last 2 **consecutive** years. One skin test will be required annually after the initial TB screening. **Students who are positive can submit the blood test.**

| Test | Test Date | Date of Completion | Results |
|--|-----------|--------------------|---------|
| TB Skin Test – 1 st Step or annual screen | | | |
| TB Skin Test- 2 nd Step or annual screen | | | |
| Chest X-ray results if TST is positive. If CXR is >1 year, complete the health assessment form and attach the form. Attachment C | | | |
| QuantiFERON TB Gold or T-Spot blood test | | | |

| Health History | Yes | No | Comments |
|--|-----|----|----------|
| Diabetes | | | |
| Seizure Disorder | | | |
| Paralysis, Paresis | | | |
| Orthopedic problems | | | |
| Hearing loss | | | |
| Impaired vision | | | |
| Heart Disease/Hypertension/Syncope | | | |
| Respiratory disease | | | |
| Allergies to drugs/foods | | | |
| List any medications taken which could alter mood or thought processes. These drugs may include, but are not limited to pain, seizure, anxiety or psychiatric medications. | | | |

Part B -Continued

Have you been treated for any of the following problems?

Substance Abuse: _____ No _____ If Yes, _____ Alcohol _____ Drugs

Emotional Problems _____ No _____ If yes, explain _____

Height _____ Weight _____ Temp _____ Pulse _____ BP _____

| | | | |
|-----------------|--------|----------|-----------|
| Hearing: | Normal | Abnormal | Corrected |
| Vision: | Normal | Abnormal | Corrected |

General Appearance:

| | NORMAL | ABNORMAL | COMMENTS |
|--|--------|----------|----------|
| Mental Status-Orientation, Affect, Cognition/memory, Judgment | | | |
| Head, face, scalp | | | |
| Eyes | | | |
| Ears | | | |
| Nose, sinuses | | | |
| Oral cavity | | | |
| Neck, nodes, thyroid | | | |
| Breasts | | | |
| Respiratory | | | |
| Cardiovascular-PMI, rhythm, Heart sounds | | | |
| Abdomen & inguinal area | | | |
| GU | | | |
| GYN | | | |
| Musculoskeletal | | | |
| Neurologic: Reflexes, Coordination, Sensory | | | |

Is there any emotional, mental, and/or physical condition for which this student is under medical supervision and/or taking medication? _____.

Part B -Continued

**** For Pregnant Students Only:**

Is this student pregnant? _____ EDC _____

____ I have examined this student and she is able to **participate fully, without restrictions** in all required clinical nursing activities.

Upon completion of the history and physical, I certify that this student is able to function in a safe and effective manner while caring for ill or injured clients in a clinical setting. The findings indicate that this student is both physically and emotionally qualified for enrollment into the program as specified in the **Technical Standards** on page 9. He/she is able to **participate fully, without restrictions** in all activities of this program. Please comment on **any findings that need further clarification.**

Comments: _____

Healthcare Provider's Name (Print)

Healthcare Provider's Signature

Date

Address

City

State

Zip

Phone Number

Attachment A

**Delgado Community College
CHARITY SCHOOL OF NURSING
450 South Claiborne Ave New Orleans, LA 70112**

Waiver of Hepatitis B Vaccine and Release from Responsibility

I, _____ understand that due to my potential of Occupational Exposure to blood or other potentially infectious materials that I may be at risk of acquiring Hepatitis B virus (HBV) infection. I am aware that Charity School of Nursing requires Hepatitis B vaccination. However, I am declining the Hepatitis B vaccination at this time. I understand that by signing this waiver, I continue to be at risk of acquiring Hepatitis B. I accept full responsibility for this personal risk. I am aware that I may not be able to have clinical experience at certain clinical sites because of contractual agreements requiring each student nurse to have Hepatitis B vaccination.

I have been fully informed by reading the Centers for Disease Control and Prevention Vaccine Information Statement @ www.cdc.gov/vaccines/pubs/vis/downloads/vis-hep-b.pdf and understand the risks associated with the vaccine and the risk of Hepatitis B infection.

A. I am declining the vaccine for:

_____personal reasons.

_____medical reasons.

_____religious reasons.

Printed Name

Student's Signature

Date

OR

B. I have not completed the Hepatitis B series and understand that I must complete the series and submit verification of completion.

Projected Date of Completion: _____

Printed Name

Student's Signature

Date

Submit to Office 619

Attachment B

**DELGAGO COMMUNITY COLLEGE
CHARITY SCHOOL OF NURSING
450 South Claiborne Avenue
New Orleans, LA 70112**

WAIVER OF MENINGOCOCCAL VACCINATION AND RELEASE FROM RESPONSIBILITY

BE IT KNOWN that on this date, I, _____
(Name of Student)

HAVE BEEN FULLY INFORMED BY READING THE CENTERS FOR DISEASE CONTROL AND PREVENTION MENINGITIS VACCINE INFORMATION STATEMENT and understand the possible and probable adverse consequences. I understand that my health could be negatively affected and my life possibly endangered by not receiving the vaccine. The reason for not being vaccinated is:

- Personal
- Unavailability of the Vaccine (I have provided a statement verifying that I have tried to receive the vaccine but could not find any.)
- I am an online student and will not be on the campus for courses.
- Medical
- Religious

I declare myself to be a person of the full age of majority and to be mentally competent. I hereby assume full responsibility for any and all possible present or future results or complications of my condition due to this refusal.

I do further hereby now and forever free and release the University and the Department of Health and Hospitals and all its agents, attending health care professionals, and other personnel from any and all legal or financial responsibility as a result of this refusal.

I certify that I have read (or had read to me) and that I fully understand this release from Responsibility. All explanations were made to me all blanks filled in before I signed my name.

Month Day Year _____ am/pm
Time

(Printed Name)

Signature

Submit to office 619

Attachment C

**DELGADO COMMUNITY COLLEGE
CHARITY SCHOOL OF NURSING
ANNUAL TUBERCULOSIS TESTING AND SCREENING**

If students are known to have a positive TB skin test, the following must be completed annually.

Date of Positive skin test: _____

Have you taken:

| | | |
|-----------------|-----------|----------|
| isoniazid (INH) | _____ Yes | _____ No |
| rifampin | _____ Yes | _____ No |
| pyrazinamide | _____ Yes | _____ No |
| ethambutol | _____ Yes | _____ No |
| streptomycin | _____ Yes | _____ No |

Did you complete treatment? _____ Yes _____ No

Do you have symptoms of TB?

| | | |
|---------------------------|-----------|----------|
| Cough for 3 or more weeks | _____ Yes | _____ No |
| Fever | _____ Yes | _____ No |
| Chills or night sweats | _____ Yes | _____ No |
| Weight loss | _____ Yes | _____ No |
| Loss of appetite | _____ Yes | _____ No |

An initial chest film is required for first time skin test converters. After the initial chest radiograph, repeat radiographs are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph.

CXR date and results: _____

Recommended follow up if indicated: _____

Comments: _____

Student's Name (PRINT): _____

Student ID number: _____

Student's Signature & Date: _____

Health Care Provider's Signature & Date: _____

Submit this form to office 619, Charity School of Nursing.

**DELGADO COMMUNITY COLLEGE
CHARITY SCHOOL OF NURSING**

Self Reporting of HBV, HCV or HIV Status to the Louisiana State Board of Nursing

Louisiana State Board of Nursing: Rules and Regulations, Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLVII. Nurses, Subpart 2. Registered Nurses

Chapter 40. Prevention of Transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV)

§4005. Self-Reporting

A. Within 90 days of the effective date of this Chapter, registered nurses, registered nurse applicants, and nursing students enrolled in a clinical nursing course who perform, or participate in, exposure-prone procedures and have been previously diagnosed as HBV, (seropositive), HCV and/or HIV seropositive shall give notice of such diagnosis to the board on a reporting form supplied by the board. Such notice shall be mailed to the compliance director, marked "Personal and Confidential" by registered or certified mail. This report shall be confidential as provided in §4001 of this Chapter, definition of confidentiality.

B. Registered nurses, registered nurse applicants, and nursing students enrolled in a clinical nursing course who know or should know that they carry and are capable of transmitting HBV, HCV or HIV and who perform or participate in exposure-prone procedures shall report their status to the Board of Nursing within 30 days from the date of the performance of the diagnostic test. They shall give notice of such diagnosis to the board on a reporting form supplied by the board which shall be mailed to the compliance director, marked "Personal and Confidential," by registered or certified mail. This report shall be confidential as provided in Act 1009 of the 1991 Louisiana Legislature.

C. Provided that the identity of the self-reporting registered nurse, registered nurse applicant or nursing student enrolled in a clinical nursing course is not disclosed, either directly or indirectly, the provisions of this Section shall not be deemed to prevent disclosure by the compliance director or the board, to governmental public health agencies with a legitimate need therefore, of statistical data derived from such reports, including, without limitation, the number and demographics of registered nurses, registered nurse applicants, and nursing students enrolled in a clinical nursing course having reported themselves as HbsAg, HCV, and/or HIV seropositive and their geographical distribution. AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918(K), and R.S. 37:1746-1747. HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Nursing, LR 19:341 (March 1993), amended LR 19:1151 (September 1993), repromulgated LR 24:1293 (July 1998), LR 30:2484 (November 2004).

Please note that HIV testing is not required. Please check the appropriate box below.

| | Positive | Negative | Unknown |
|------------|-----------------|-----------------|----------------|
| HCV | | | |
| HBV | | | |
| HIV | | | |

Reporting seropositivity of any of the above to the LSBN is the responsibility of the applicant.

Printed Name

Applicant's Signature

Date

DELGADO COMMUNITY COLLEGE
CHARITY SCHOOL of NURSING
Technical Standards

Students must continue to meet the required technical standards of nursing practice. Technical standards reflect the abilities required to provide safe, competent nursing care. The student must have the

1. Communication skills in speech and writing, in the English language.
2. Speaking ability to be able to converse with a client about their condition and to relay information about the client to others.
3. Interpersonal skills to adapt and interact with individuals, families and groups from various socioeconomic, cultural, and intellectual backgrounds.
4. Hearing ability with auditory aids to understand the normal speaking voice without viewing the speaker's face (to ensure that the nurse will be able to attend to a client's call for help either softly or as a cry) and to hear high and low pitched sounds with a stethoscope.
5. Visual acuity with corrective lenses to identify visual changes in a client's condition/color, perceive depth of injections, or to see small numbers on medical supplies.
6. Sense of smell sufficient to detect odors.
7. Sense of touch sufficient to perform palpation, percussion, and distinguish temperature changes.
8. Strength and psychomotor coordination necessary to perform technical nursing procedures and cardiopulmonary resuscitation (at floor or bed level) including lifting and carrying (at least 20 lbs) and pushing or pulling an adult client of average weight in a wheelchair or on a stretcher.
9. Motor skills requiring manual dexterity such as putting on sterile gloves, preparing medications in syringes, giving injections, or inserting various tubes and catheters.
10. Emotional ability to manage stress and adapt to changes in the environment or a client's behavior/health status in an effective, therapeutic manner including responding to anger, fear, hostility, and violence of others.
11. Problem solving/critical thinking ability to:
 - a. Collect, read and interpret data.
 - b. Use the data to plan and implement a course of action.
 - c. Prioritize and adapt care.
 - d. Evaluate the action taken.
12. Stamina to fulfill the requirements of the program and customary requirements of the profession, e.g. sit, stand, stoop, kneel, climb and/or bend for a period of time and work in areas that are confined and/or crowded during a clinical experience which may last up to 12 hours.

NOTE: Each clinical nursing course has identified specific psychomotor nursing skills that the student must satisfactorily perform based upon written criteria. If unable to satisfactorily demonstrate each of these skills, the student may not continue in the clinical experience and will receive a grade of "F" in the course.

Summer 2011