NURSING DEPARTMENT CERTIFICATE OF HEALTH STATEMENT

RELEASE AUTHORIZATION

I hereby authorize Tompkins Cortland Community College to furnish to the institutions named below medical records and information pertaining to medical history, mental or physical condition, or treatment of the person named below for the purposes of ensuring that students/faculty are physically and mentally able to perform patient care, related duties, or for any other purpose reasonably related to these activities.

I understand that the institutions named below may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I further understand that I have a right to receive a copy of this authorization upon my request.

Signed_____ Date_____

Witness_____ Date_____

_____ _____

Patient Name: Last, First, Middle Birthdate: mm/dd/yy

Copy received? ☐ Yes ☐ No

PLEASE RELEASE INFORMATION TO: ALL AGENCIES USED FOR CLINICAL EXPERIENCES AS NECESSARY.

On or before July 15 mail to: TC3 Health Services, Tompkins Cortland Community College, 170 North Street, P.O. Box 139, Dryden, NY 13053-0139, or fax to: (607) 844-6533. If faxing, print clearly on the fax cover sheet: Student's name, date of birth, and "Nursing Student."

Nursing Department Certificate of Health Statement

Name: _____ Date of Birth _____

Address:_____City: _____

Zip Code: _____Telephone: (home) _____(work)_____

- ***Tuberculin Skin Test (P.P.D. only)*** ***Complete the option that applies:***
  a) If has had a negative P.P.D. within the past 12 months, need additional one within 6 months prior to clinical rotation.
  #1 Date _____ Result _____mm
  #2 Date _____ Result _____mm

  b) If **no** P.P.D. within the past 12 months, need 2 P.P.D.'s one to three weeks apart and within 6 months prior to clinical rotation.
  #1 Date _____ Result _____mm
  #2 Date _____ Result _____mm

  c) If P.P.D. is positive: A chest X-Ray is required within 6 months prior to clinical rotation unless medically contraindicated. (Must provide evidence of negative chest x-ray.)
  X-Ray Date _____ Result _____
  Did the student have treatment for the positive skin test? Yes ____No ____
  If yes, describe medications and duration

- ***Chickenpox/Shingles/Varicella***
  Date of titer _____ Result_____(Attach copy of lab results)
  Immunization Date 1)_____ **2)**_____

- ***Tdap:*** **(**Recommended if last tetanus immunization was more than 5 years ago)
  Date of Tdap immunization _____

- ***Tetanus*** (needed within 10 years) Date of last tetanus immunization _____

- ***Hepatitis B vaccine***

Date(1)_____(2)_____(3)_____

- ***Measles/Mumps/Rubella (MMR)***

  Option 1: MMR Vaccination Dose Date (1)_____ Dose Date (2)_____

  Option 2: Measles titer date _____
  Mumps titer date _____
  Rubella titer date _____
  (Attach copies of laboratory results for titers.)

Print name of health care provider_____Date _____

Signature of health care provider_____Phone number_____

Address_____City_____Zip_____

MENINGITIS RESPONSE

Show proof of vaccination within the last 5 years OR decline and sign

I have had the Menomune™ (MPSV4) vaccine within the past 5 years.
If received prior to February 2005, the Menomune™ vaccine protects 3-5 years from when received.

Date received: _____

I have had the Menactra™ (MCV4) vaccine within the past 5 years.

Date received: _____

-OR –

☐ **I will not obtain immunization against meningococcal meningitis disease.** I have read, or have had explained to me, the information regarding meningococcal meningitis disease.
I understand the risks of not receiving the vaccine.

STUDENT SIGNATURE

_____

Detailed information with regards to this form can be found at www.tc3.edu/student/forms.asp

NURSING DEPARTMENT CERTIFICATE OF HEALTH STATEMENT
Report of Physical Examination

Last Name _____First Name _____ Middle _____Date of Exam _____

Clinical Evaluation (Check each item in appropriate column, "NE" is not evaluated)

	Normal	Abnormal	Notes: Describe abnormality
1. Head, face, neck and scalp			
2. Nose			
3. Mouth, tongue, and throat			
4. Ears, General			
5. Eyes			
6. Lungs, and chest (breasts)			
7. Heart (thrust, size, sounds, and rhythm)			
8. Vascular system (varicosities)			
9. Abdomen and viscera (hernia)			
10. Endocrine system – Thyroid			
11. GU system			
12. Upper extremities			
13. Lower extremities			
14. Spine, Musculoskeletal			
15. Skin, Lymphatics			
16. Neurologic			

MEASUREMENT and OTHER FINDINGS

Height: _____ Weight: _____ Build: Slender, Medium, Heavy, Obese (circle one)

Blood pressure (arm at heart level) Sitting: Systolic _____ Pulse _____
Diastolic _____ Temperature _____

Gross Vision: O.D. _____ O.S. _____

Gross Hearing: Right ear _____ Left ear _____

In your assessment, is this patient mentally, physically and emotionally ready for the emotional and physical rigors for college nursing curriculum? If no, please explain your answer on separate paper and attach to form.

_____

_____

_____

Signature_____

Date_____