

1. NAME: _____ SS# _____ DATE: _____

2. ADDRESS: _____ TELEPHONE: _____

3. VITAL SIGNS: T _____ P _____ R _____ BP _____

4. **CURRENT / PAST HISTORY:** (Past/current allergies, illnesses, surgeries, injuries with dates, treatment & results) _____

5. **PHYSICAL EXAMINATION** (Dates, Results & R/U as needed):
HEAD/NECK: EYES, EARS, NOSE, THROAT: _____

VISION: WITHOUT GLASSES: R 20/ _____ L 20/ _____ CORRECTED: R 20/ _____ L 20/ _____

HEARING: R _____ L _____

SKIN: _____

HEART / VASCULAR: _____

LUNGS: _____

ABDOMEN: _____

MUSCULO / SKELETAL: POSTURE / BACK _____

EXTREMITIES / FEET _____

GENITO/URINARY _____

6. **REQUIRED LABORATORY AND DIAGNOSTIC TESTS:** (Dates, Results & F/U as needed):

TUBERCULIN SKIN TEST DATE _____ RESULTS _____

DATE _____ RESULTS _____

CHEST X-RAY (as needed) DATE _____ RESULTS _____

FOLLOW-UP AS NEEDED _____

7. **REQUIRED IMMUNIZATIONS** (Dates of Immunization or Disease):

HEPATITIS B: Dose 1: _____ Dose 2: _____ Dose 3: _____

MMR: Dose 1: _____ Dose 2: _____ TITER: _____

DIPHTHERIA / TETANUS _____ LAST BOOSTER _____

VARICELLA: History: _____ Vaccine: _____ Titer: _____

POLIO (Required if under 19) _____ BOOSTER _____

8. **DISABILITIES AND ACTION NEEDED:** _____

9. **IN YOUR OWN OPINION IS THIS INDIVIDUAL IN SUITABLE PHYSICAL AND EMOTIONAL
CONDITION FOR NURSING? IF NOT, WHY?** _____

SIGNATURE OF EXAMINING PHYSICIAN

STREET ADDRESS CITY STATE ZIP

PLEASE PRINT LAST NAME

(_____) _____
TELEPHONE

DMC/RN: FORM REVIEWED & FOUND COMPLETE BY _____ **DATE** _____

DEL MAR COLLEGE - - DEPARTMENT OF NURSE EDUCATION

POLICY FOR TUBERCULOSIS SKIN TESTING

All student nurses are required to have a tuberculosis skin test:

1. Upon admission to the Program;
2. Annually; and
3. Following a known exposure.

A physical examination on the applicant is required prior to admission following acceptance in the Del Mar College Department of Nurse Education. A tuberculosis skin test and follow-up is a mandatory part of the examination. Proof includes a document negative tuberculosis skin test within 6 months or less of admission into the Program. If the student has a positive skin test or converts to a positive skin test, policy requires that the student:

1. Have an initial chest x-ray with no indication of disease;
2. Complete the following questionnaire by their physician on a yearly basis.

TUBERCULOSIS SURVEILLANCE SCREENING FOLLOWING POSITIVE SKIN TEST

STUDENT NAME _____

BIRTH DATE: _____ **DATE OF CONVERSION:** _____

I. DATE OF QUESTIONNAIRE _____

Do you have?		YES	NO	COMMENTS
1	Fatigue, Malaise			
2	Unexplained weight loss			
3	Loss of appetite			
4	Fever (usually at night)			
5	Night sweats (drenching type)			
6	Cough			
7	Spitting up blood (hemoptysis)			
8	Pain in chest			

I find _____ free of signs and symptoms of Tuberculosis and eligible to continue as a Del Mar College nursing student:

SIGNATURE OF PHYSICIAN _____ DATE _____

II. DATE OF QUESTIONNAIRE _____

Do you have?		YES	NO	COMMENTS
1	Fatigue, Malaise			
2	Unexplained weight loss			
3	Loss of appetite			
4	Fever (usually at night)			
5	Night sweats (drenching type)			
6	Cough			
7	Spitting up blood (hemoptysis)			
8	Pain in chest			

I find _____ free of signs and symptoms of Tuberculosis and eligible to continue as a Del Mar College nursing student:

SIGNATURE OF PHYSICIAN _____ DATE _____

Use other side for additional information.