

# PRE-ENTRANCE MEDICAL RECORD



COMPLETE AND TURN IN NO LATER THAN:

JULY 13, 2012

Drop your record off in the “Locked Drop Box” located just outside of Room 169 in the Health Technology Center on main campus; or mail to Fayetteville Technical Community College; Attn: Health Programs, PO Box 35236, Fayetteville, NC 28303-0236

For further assistance, please contact your Health Program Department Chair

PLEASE CHECK YOUR HEALTH PROGRAM BELOW to ensure your record is provided to your program.

- |  |   |
|--|---|
| <input type="checkbox"/> Associate Degree Nursing    | <input type="checkbox"/> Pharmacy Technology          |
| <input type="checkbox"/> Central Sterile Processing  | <input type="checkbox"/> Physical Therapist Assistant |
| <input type="checkbox"/> Dental Assisting            | <input type="checkbox"/> Practical Nursing            |
| <input type="checkbox"/> Dental Hygiene              | <input type="checkbox"/> Radiography                  |
| <input type="checkbox"/> Emergency Medical Science   | <input type="checkbox"/> Respiratory Therapy          |
| <input type="checkbox"/> Nuclear Medicine Technology | <input type="checkbox"/> Speech Language Pathology    |
| <input type="checkbox"/> Nursing Assistant           | <input type="checkbox"/> Surgical Technology          |

**GUIDELINES FOR COMPLETING IMMUNIZATION RECORD  
FOR HEALTH PROFESSION PROGRAM STUDENTS**

**IMPORTANT:**

- Records must be documented in black INK and all corrections must be signed.
- All dates must include month, day and year of administration.
- Immunizations required for the appropriate age group as outlined below must be documented in "SECTION A" of the Pre-Entrance Medical Record provided by the educational institution.

**Immunizations That ARE REQUIRED Pursuant to NC State Law**

**Students 17 years of age or younger.....REQUIRED:**

- 3 DTP(Diphtheria, Tetanus, Pertussis) or Td(Tetanus, Diphtheria) doses;  
One TD booster must have been within the past 10 years.
- 3 Polio (oral) doses
- 2 Measles (Rubeola), 1 Mumps, 1 Rubella (MMR is preferred vaccine) or positive blood titers for Measles, Mumps and Rebella
- 3 Hepatitis B or positive blood titer
- 2 Varicella or positive blood titer (history of disease insufficient as proof of immunity)
- Tuberculin skin test with negative result within the 12 months preceding the first day of classes (chest x-ray with negative result required if skin test positive, or documentation of Tuberculosis vaccination.)

**Students born in 1957 or later and at least 18 years of age.....REQUIRED:**

- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD(tetanus, Diphtheria) doses; one Td booster must have been within the past 10 years.
- 2 Measles (Rubeola), 1 Mumps, 1 Rubella (MMR is preferred vaccine) or positive blood titers for Measles, Mumps and Rubella.
- 3 hepatitis B or positive blood titer
- 2 Varicella or positive blood titer (history of disease insufficient as proof of immunity)
- Tuberculin skin test with negative result within the 12 months preceding the first day of classes (chest x-ray with negative result required if skin test positive, or documentation of Tuberculosis vaccination.)

**Students born before 1957.....REQUIRED:**

- 3 DTP (Diphtheria, Tetanus, Pertussis) or TD(tetanus, Diphtheria) doses; one Td booster must have been within the past 10 years.
- 3 hepatitis B or positive blood titer
- 2 Varicella or positive blood titer (history of disease insufficient as proof of immunity)
- Tuberculin skin test with negative result within the 12 months preceding the first day of classes (chest x-ray with negative result required if skin test positive, or documentation of Tuberculosis vaccination.)

**NOTE:** History of Measles (Rubeola) is acceptable if physician verifies that student had the disease prior to January 1, 1994.

**Additional Immunizations REQUIRED by Fayetteville Technical Community College and Contracted Clinical Sites FOR ALL HEALTH PROGRAM STUDENTS include:**

- 1 Tdap unless vaccinated for tetanus within the last 2 years
- Other immunizations may be required by certain departments for clinical participation. Consult your department chair for specific requirements.

# IMMUNIZATION RECORD (Please type or print in black ink – no white out)

<b>Last Name</b>	<b>First Name</b>	<b>Middle Name</b>	<b>Date of Birth (mo./day/year)</b>	<b>Student ID Number</b>

## SECTION A

**REQUIRED Immunizations for All Health Program Students (see enclosure “Guidelines for Completing Immunization Record for All Health Program Students” to determine immunizations)**

Immunization	mo/day/year	mo/day/year	mo/day/year	mo/day/year
	#1	#2	#3	#4
• DPT or Td				
• Td Booster				
• Tdap (if no tetanus immunization within last 2 years)				
• Polio (if 17 yrs of age or younger)				
• Measles (MMR) (Rubeola, Red Measles)				Titer Date & Result
• Mumps (MMR)				Titer Date & Result
• Rubella (MMR)				Titer Date & Result
• Tuberculin Skin Test (PPD): (within past 12 months of class start date) Date Placed: Date Read: Mm of Induration:				
• Chest X-Ray, if positive TB Skin Test Date: Results:				
• Written TB Screening, if positive TB Skin Test (CXR and Written TB Screening required if positive TB Skin Test) Date: (Use DHHS Form 3405) Results:				
• Hepatitis B Series				Titer Date & Result
• Varicella (Chickenpox) **Date of disease is NOT sufficient for proof of immunity				Titer Date & Result

## SECTION B

**Other immunizations that may be required by program based on clinical facility requirements. Check with department chair first.**

	mo/day/year	mo/day/year	mo/day/year
• Influenza			
• Pneumococcal			
• Other			

### Clinician Information

Signature or ClinicStamp \_\_\_\_\_ Telephone \_\_\_\_\_

Office Address: \_\_\_\_\_ Date: \_\_\_\_\_

Do Not Write in this Space

**PHYSICAL EXAMINATION (Please type or print in black ink – no white out)**

Last Name			First Name	Middle Name	Date of Birth (mo/day/yr)	Student ID Number
Permanent Address			City		State	Zip Code
						Area Code/Phone Number

Height \_\_\_\_\_ Weight \_\_\_\_\_ TPR \_\_\_\_\_ B/P \_\_\_\_\_ / \_\_\_\_\_

<b>VISION</b>	Corrected : Right 20/ _____ Left 20/ _____
	Uncorrected: Right 20/ _____ Left 20/ _____ Color Vision _____

**SYSTEMS REVIEW**

Are there abnormalities? If so, describe fully	YES	NO	DESCRIPTION (attach additional info)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Metabolic/Endocrine			
8. Musculoskeletal			
9. Neuropsychiatric			
10. Skin			
11. Mammary			

- A. Is there loss or seriously impaired function of any paired organs? Yes \_\_\_ No \_\_\_  
Explain \_\_\_\_\_
- B. Is student under treatment for any medical or emotional condition? Yes \_\_\_ No \_\_\_  
Explain \_\_\_\_\_
- C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited \_\_\_  
Limited \_\_\_ Explain \_\_\_\_\_
- D. Is student physically and emotionally health? Yes \_\_\_ No \_\_\_  
Explain \_\_\_\_\_

<b>Only for Students Admitted to a Health Program – Must be Completed by Physician, PA or NP</b>
Based on my assessment of this student’s physical and emotional health on _____, he/she appears able to participate in the activities of a health profession in a clinical setting. YES ___ NO ___ If No, please explain _____

\_\_\_\_\_  
Signature of Physician/Physician Assistant/Nurse Practitioner \_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Physician/Physician Assistant/Nurse Practitioner

Office Address \_\_\_\_\_ Area Code/Phone Number \_\_\_\_\_

**REPORT OF MEDICAL HISTORY (Please type or print in black ink)**

LAST NAME (print) FIRST NAME MIDDLE NAME STUDENT ID NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE

Date of Birth (mo/day/year) Gender  MALE  FEMALE Marital Status

Name of PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP AREA CODE/PHONE

ADDRESS OF EMERGENCY CONTACT CITY STATE ZIP CODE

**IMPORTANT INFORMATION – PLEASE READ AND COMPLETE**

**STATEMENT BY STUDENT:** I have personally supplied the above and enclosed information and attest that it is true and complete to the best of my knowledge. I understand that though the information will be treated as strictly confidential as possible, it may be released, only as appropriate and necessary to satisfy the requirements of clinical facilities where I am assigned to participate in clinical rotation. I hereby give consent for Fayetteville Technical Community College and representatives thereof to release any contents of this health immunization record strictly for the purpose of satisfying the above mentioned clinical facility requirements. I also consent to the release of this information to faculty members within my academic curriculum for the purpose of meeting my educational requirements. No other releases are allowed without my expressed written consent.

Signature of Student or Student's Legal Guardian, if student is a minor.

Date