NORTHEAST
MISSISSIPPI COMMUNITY COLLEGE
DIVISION OF HEALTH SCIENCES

Division of Health Sciences • 101 Cunningham Blvd • Booneville, Mississippi 38829
Phone (662) 720-7236/(800) 555-2154

NORTHEAST MISSISSIPPI COMMUNITY COLLEGE
DIVISION OF HEALTH SCIENCES
Medical Examination

Full Name: ____
(Last) (First) (Middle/Maiden)

Address: ____
(Street, Apt #) (City) (State) (Zip Code)

Student ID:______________________ Date of Birth: ____________________
* *

MEDICAL HISTORY (**To be completed by the client/student**): Do you presently have or have you ever had a history of any of the following? Please mark either yes or no for each section. Any 'yes' answers **MUST** be described in the comments section.

	YES	NO		YES	NO
1. Heart Disease			13. Lung Disease		
2. Kidney Disease			14. Musculo-Skeletal Disorders		
3. Cancer			15. Childhood Diseases		
4. Hypertension			16. Difficult Pregnancy		
5. Diabetes			17. Allergies		
6. Mental/Emotional Disorder			18. Other Diseases (list)		
7. Neurological Disorder			19. Hospitalizations		
8. Seizures (Epilepsy)			20. Serious Illness		
9. Cognitive Disorder			21. Liver Disorders		
10. Immune Disorder			22. Are you presently under the care of a physician? (*explain*)		
11. Blood Disorder			23. Lifestyle habits/practices (*list*) i.e., smoking, alcohol use, etc.		
12. Are you currently receiving any therapy/medication? (*list*)			24. Vision Problems / Hearing Problems / Speech Problems		

COMMENTS (identify by reference number): ____

____
____
____
____
____
____
____
____

I attest the information above is accurate to the best of my ability to determine. I understand that should my health status change on the above listed items (#1-24) while I am enrolled in a health sciences program, I am to report these changes to the Program Director and provide documentation as requested or deemed necessary.

______________________________ ____________________
(Signature of Client/Student) (Date)

Name of client: ________________________________ **Date of Physical Exam:** ______________

TO PRIMARY CARE PROVIDER: Each item on the pre-entrance medical form must be completed in order to meet contractual guidelines of affiliating agencies and the health sciences programs. If you do not provide diagnostic services for any of the requested data, please refer the applicant to the appropriate agency. Thank you.

Academic Head, Division of Health Sciences

* *

PHYSICAL EXAMINATION (Must be completed by the PRIMARY CARE PROVIDER);

General State of Health ____

Vital Signs: Temp ______________ Pulse_______ Resp___________B/P_______________________

Nutritional Status ____

Mental Status____

Skin ____

Head (and neurologic status) ____

Eyes, Ears, Nose, Throat (describe vision / hearing / teeth) ______________________________

Lungs____

Heart (rhythm, murmur, rub) ____

Breasts____

Abdomen ____

Musculoskeletal ____

Genitourinary (please include menstrual history, bowel / bladder problems) _________________________

Hemoglobin or Hematocrit Test: _____________ **Date:**____________ **Results:** ______________

Statement of Eligibility (to be completed by the Physician / Nurse Practitioner)

Health Sciences/Nursing is "a practice discipline with cognitive, sensory, affective, and psychomotor performance requirements."

(Southern Council on Collegiate Education for Nursing Task Force)

A person practicing in the health sciences must have intellectual, interpersonal, and communication skills. In addition, certain other abilities are necessary including: (1) emotional stability sufficient to assume responsibility / accountability for actions; (2) fine motor ability sufficient to perform skills such as picking up, grasping, and manipulating small objects with the hands; (3) physical mobility and strength sufficient to move about on a nursing unit and participate in client care (this involves lifting , standing, stooping, pushing); (4) physical stamina sufficient to perform client care for the length of a work shift; (5) auditory ability sufficient for assessment of client health; and (6) visual acuity sufficient to see objects, to read fine print, and to distinguish color.

(*National Council of State Boards of Nursing*)

Based on this history and physical assessment, it is my opinion that________________________should be able to meet the requirements identified above.

Based on this history and physical assessment, it is my opinion that_________________________should be able to meet the requirements identified above with the exception of______________________________ with the following restriction_______________________________or recommendations _________________

(signature) ____________________ **(title)** ____________________ **(date)** ____________________

(address) ________________________________ **(telephone)** ________________________________

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Health Requirements

Required immunization documentation should be submitted on a State Public Health Form 121, easily accessible to all clinics and health departments.

Physical Examination ○ Print form and have health care provider complete ○ Must include hemoglobin or hematocrit result
Negative drug screen (at least 9 panel)
TB – Must have DOCUMENTATION of 2 TB skin test results OR one QFT result. 1. Proof of previous TB skin test (1) **AND** current TB skin test (2) that will go through May **OR** 2. Two-step test – those who have not had a TB skin test within twelve months. The two-step includes an initial TB skin test (1) with a second TB skin test (2) within 7-21 days **OR** **3.** QuantiFERON®-TB Gold Test (QFT) or equivalent test that will go through May. ***Chest X-ray if TB test is contraindicated with proof of date and results.*** *Students with positive TB tests must be further evaluated and follow the recommendations of the Public Health Department.*
Rubella *(Validate by one of the identified methods. NOTE: the vaccine is contraindicated with pregnancy or conception within 3 months of immunization)* **Proof of 2 immunizations** **OR** **Proof of Positive Rubella Titer** **OR** **Birth before 1957; Date of Birth**
Hepatitis B Vaccine *(Validated by one of the identified methods)* **Proof of 3 immunizations** *(Completed or in process of receiving all 3 at recommended time intervals)* **OR** **Proof of Positive Hepatitis B Titer**
Proof of Tetanus/Diptheria/Pertussis (TDaP) vaccination since childhood DTaP (usually given AROUND the age of 11-12) **and a tetanus containing vaccine within the last ten years** *(If Tdap wasn't received in past 8 years, it won't carry you through graduation, so you will be required to receive a Td immunization.*
Varicella (Chicken Pox) *(Validated by one of the identified methods)* **Documented positive titer,** **OR** **Documentation of two (2) varicella vaccinations**
Influenza-FLU Vaccine *(Must submit documentation BY October 1st annually)*

Students returning to second year:

- Must submit proof of annual TB skin test that will be in effect until next May.

Students readmitted to a program:

- Same requirements as a new student

COVID requirements may be necessary prior to attending clinical experiences in local facilities.

Revised August 2018, August 2019, June 2020.

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Physicians Urgent Care has a certified MRO who can receive and review drug screening results and evaluate medical explanations for certain drug test results. (14 panel is checked on the form b/c you need at least a 9 panel, but not a DOT panel.) If you choose to complete your drug screening at a different clinic and you have a positive result, you will need to have a certified MRO to evaluate your results. The Health Science programs will not accept a positive result.

PHYSICIANS URGENT CARE
Phone (662)287-7138 Fax (662)287-7157
OCCUPATIONAL MEDICINE AUTHORIZATION

Student Name: ______________________

Company requesting testing: NEMCC Division of Health Sciences

Program of Study (Please check one):

- Associate Degree Nursing (662) 720-7773 ___
- Dental Hygiene Technology (662) 720-7459 ___
- Medical Assisting Technology (662) 720-7393 ___
- Medical Laboratory Technology (662)720-7403 ___
- Practical Nursing (662) 720-7288 ___
- Respiratory Therapy Technology (662) 720-7364 ___
- Radiologic Technology (662) 720-7466 ___
- Other: ______________________________

PLEASE CHECK THE TEST YOU WANT PERFORMED ON THIS STUDENT.

Physicians Urgent Care will not perform a drug screen without this form. Please carry this form with you.

____ Drug testing Collection only to be sent to your contracted lab
(must bring ID)
Must be in our office at least 1 hour prior to closing time

____ Drug Screen 5-panel Quick test **(must bring ID)**
Must be in our office at least 1 hour prior to closing time

__X_ Drug Screen 14-panel Quick test **(must bring ID)**
Must be in our office at least 1 hour prior to closing time

___ DOT drug testing)**must bring ID)**
Must be in our office at least 3 hours prior to closing time

Requested by: Jennifer Davis Date: ______________

Email results to: jlramey@nemcc.edu

Booneville Clinic Hours: Monday – Friday 8:30am-4:30pm