BLUEFIELD STATE COLLEGE
DEMOGRAPHIC SHEET
PAGE 1

I. Personal Data

Name _____

BSC ID# _____ Date of Birth _____

Present Address _____

_____

Telephone: Home_____ Work/Cell _____

Sex(Circle one): Male Female

Permanent Home Address _____

_____

BSC Email Address _____

Other Email Address _____

II. Next of Kin

Name of Next of Kin _____

Relationship _____

Address _____

_____

Telephone: Home_____ Work/Cell _____

In case of Emergency, who should we notify:

Name _____

Relationship _____

Address _____

_____

Telephone: Home_____ Work/Cell _____

III. Healthcare Provider/Insurance Information

Name Address of your health care provider:

Name _____

Degree _____(M.D., N.P., D.O.)

Address _____

_____

Medical Insurance Company _____

Policy Number _____

IV. Current Health Information

1. Please list any allergies we can accommodate, for example latex.

Drug:_____

_____

Food:_____

_____

Other (Ex. Latex)_____

_____

Demographic Sheet
Page 2

Name _____

VI. Physical Examination

A physical examination by your health care provider is required within three months of admission and due to the program no later than the first day of class. This is for your safety in performing in the clinical setting. Technical Standards are included in this packet and should be reviewed by yourself and your healthcare provider during your visit. It is not necessary for us to know the results of all your physical examination, only that you and your provider have reviewed the standards and feel you are able to meet these standards.

I certify that this patient is free of any communicable disease and is capable of providing health care in a clinical setting.

_____ _____
Signature of Student Date

_____ _____
Signature of Health Care Provider Date

_____ _____
Printed Name of Health Care Provider Date

Once you have been formally notified of acceptance into the appropriate program in The School of Nursing and Allied Health you will need to complete this form and upload to Castlebranch. You will be given the information needed for upload from the Program Director.

PHYSICAL EXAM SHEET

THE FOLLOWING PAGE IS BE COMPLETED BY THE EXAMINING HEALTH CARE PROFESSIONAL.

Name:_____

Weight _____ Height _____

Temperature _____

Pulse _____

Respirations _____

B/P _____

Vision (L) _____ (R) _____ WITHOUT CORRECTION (L) _____ R) _____ WITH CORRECTION

Hearing (L) _____ (R) _____

Color Blindness ☐ Yes ☐ No

Note Normal or Abnormal with Explanation

	Normal	Abnormal	Explanation
Skin/Nails			
Head/Neck			
Fundoscopic Exam			
Otoscopic Exam			
Sinuses			
Mouth			
Thorax			
Respiratory			
Cardiovascular			
Heart Sounds			
Breast			
Abdomen			
Peripheral Pulses			
Extremities			
ROM			
Gait/Posture			
Cranial nerves			
Reflexes			
Motor Function			
Sensory Function			
Romberg's Sign			

Signature of Certified Health Care Professional **Date**

THE NEXT TWO PAGES TO BE COMPLETED BY STUDENT

BLUEFIELD STATE COLLEGE
School of Nursing and Allied Health
Health History Sheet PAGE 1

Name: _____

Have you ever had problems, symptoms or treatment for the following?

	Yes	No		Yes	No		Yes	No
SINUSITIS			TUBERCULOSIS			NERVOUS DISORDER		
HEADACHES			ARTHRITIS			HEPATITIS		
STREP THROAT			RHEUMATISM			HIV INFECTION		
THYROID PROBLEM			GOUT			AIDS		
ANEMIA			BACK PROBLEMS			HOSPITAL–LAST 5 YRS		
WEIGHT CHANGE			SPINAL DISORDER			SURGERY–LAST 5 YRS		
SKIN DISORDERS			LIVER DISORDER			TAKING MEDICATIONS		
GLAUCOMA			GALLBLADDER			TOBACCO USE		
CATARACTS			ULCERS			ALCOHOL USE		
HEARING DIFFICULTY			HERNIA			OTHER DISORDERS		
DIABETES			CANCER			OTHER INJURIES		
BLOOD PRESSURE			TUMORS			COLITIS		
STROKE			KIDNEY DISORDER			FREQUENT CONSTIPATION		
RHEUMATIC FEVER			BLADDER DISORDER			FREQUENT DIARRHEA		
HEART DISEASE			EPILEPSY			LATEX ALLERGY		
CHEST PAINS			CONVULSIONS			SHORTNESS OF BREATH		
FAINTING			RANGE OF MOTION			FINE MOTOR SKILLS		
ASTHMA			INVOLUNTARY MOVEMENT			EMPHYSEMA		
MENTAL DISORDER								

Fully explain all “yes” answers with dates: _____

_____

HEALTH HISTORY SHEET

NAME _____ **PAGE 2**

Do you have a history of any illnesses not listed above and if so explain: _____

_____

_____

_____

List any current illness/condition and treatment:

Illness/Condition	Treatment/Medications

School of Nursing and Allied Health
Documented Disabilities/Accommodations Notification Form

When applicants or students disclose a disability, the provision of reasonable accommodations will be considered in an attempt to assist these individuals in meeting required technical standards.

Completion of this form is required by all students in the nursing, radiologic technology, and sonography programs.

Designate one of the following:

☐ _____ Has no documented disabilities or accommodations
(Student) to be addressed at this time.

☐ _____ Has the following documented disabilities at this time:
(Student)

Accommodations requested:

_____
Health Provider's Signature

_____
Date

_____
Health Provider's Printed Name

_____
Students' Signature

_____
Date

Hepatitis B Immunization Verification Sheet

Name_____Program_____

Hepatitis B is a serious disease caused by a virus that attacks the liver. The virus, which is called hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. (CDC, 2013)

Hepatitis B vaccine is available for all age groups to prevent HBV infection. Due to contact in the clinical practicums, we strongly encourage receiving the Hepatitis B vaccine for your protection. If you have had the vaccine in the past, please submit the dates the series was completed and the titer results. If you choose not to receive the vaccine, you must sign a waiver. Waivers are available in the offices of the School of Nursing and Allied Health.

If you are just starting the series, it is up to the student to provide documentation to Castlebranch each time you receive an injection and a titer. Documentation of all three injections and titer are required. A negative titer will require further injections and/or titer upon recommendations of provider. Failure to comply could result in removal from clinical setting per agency policies.

Must complete both criteria one and two to comply with SNAH policy

Criteria One:

Injection One_____
Date

Injection Two_____
Date

Injection Three_____
Date

Criteria Two:

Obtain HEP B titer 1-2 months after third injection (must provide actual documentation of lab results). If negative, will require further action by the student.

Result of Titer_____

Date _____

_____
Signature of Provider
(Must be signed by a licensed health care professional)

Measles, Mumps, Rubella (MMR) Immunization Verification Sheet

Name_____ Program_____

Measles is the most deadly of all childhood rash/fever illnesses. The disease spreads very easily, so it is important to protect against infection. To prevent measles, children (and some adults) should be vaccinated with the measles, mumps, and rubella (MMR) vaccine. Two doses of this vaccine are needed for complete protection. Children should be given the first dose of MMR vaccine at 12 to 15 months of age. The second dose can be given 4 weeks later, but is usually given before the start of kindergarten at 4 to 6 years of age.

Use of mumps vaccine (usually administered in measles-mumps-rubella [MMR] or measles-mumps-rubella-varicella [MMRV] vaccines) is the best way to prevent mumps. Children should be given the first dose of mumps vaccine soon after their first birthday (12 to 15 months of age). The second dose is recommended before the start of kindergarten. You should know that outbreaks of mumps still occur in the United States.

The rubella vaccine is a live attenuated (weakened) virus which is usually given as part of the MMR vaccine (protecting against measles, mumps, and rubella). MMR is recommended at 12-15 months (not earlier) and a second dose when the child is 4-6 years old (before kindergarten or 1st grade).

Rubella vaccination is particularly important for non-immune women who may become pregnant because of the risk for serious birth defects if they acquire the disease during pregnancy (CDC, 2013)

NOTE: Rubella vaccine is NEVER given to a woman who may be pregnant. A woman who receives the rubella vaccine must use an effective method of birth control for three months after the vaccine is administered.

Must complete both criteria one and two to comply with SNAH policy

Negative immunity will require a booster.

Criteria One: Record of Two MMR vaccinations received after one year of age.

Injection One_____
Date
Injection Two_____
Date

Criteria Two: Serology for Measles, Mumps and Rubella showing immunity (copy of lab results must be submitted with form)

Measles: Date_____ Value of titer_____
_____Positive Immunity _____Negative Immunity _____Borderline

Mumps: Date_____ Value of titer_____
_____Positive Immunity _____Negative Immunity _____Borderline

Rubella: Date_____ Value of titer_____
_____Positive Immunity _____Negative Immunity _____Borderline

_____
Signature of Provider
(Must be signed by a licensed health care professional)

Tetanus/Diphtheria/Pertussis (Tdap) Immunization Verification Sheet

Name_____ **Program**_____

Tetanus (lockjaw) is a serious disease that causes painful tightening of the muscles, usually all over the body. It can lead to "locking" of the jaw so the victim cannot open his mouth or swallow. Tetanus leads to death in about 1 in 10 cases. Several vaccines are used to prevent tetanus among children, adolescents, and adults including Tdap, Tdap, DT, and Td.

Diphtheria causes a thick covering in the back of the throat. It can lead to breathing problems, paralysis, heart failure, and even death. There are several combination vaccines used to prevent diphtheria: TDAP, Tdap, DT, and Td.

Pertussis is an acute infectious disease caused by the bacterium Bordetella pertussis. In the 20th century, pertussis was one of the most common childhood diseases and a major cause of childhood mortality in the United States. Before the availability of pertussis vaccine in the 1940s, more than 200,000 cases of pertussis were reported annually. Since widespread use of the vaccine began, incidence has decreased more than 80% compared with the pre-vaccine era.

However, since the 1980s there's been an increase in the number of reported cases of pertussis. In 2010, 27,550 cases of pertussis were reported—and many more cases go unreported. (CDC, 2013)

The Tdap immunization/booster must be completed within ten years of admission to the program and must maintain currency while in the program.

It is up to the student to provide documentation to Certified Backgrounds each time you receive a booster. Failure to comply could result in removal from clinical setting per agency policies.

Date of Tdap _____

_____
Signature of Provider
(Must be signed by a licensed health care professional)

Tuberculosis Screening Verification Sheet

Name_____ Program_____

Tuberculosis (TB) is caused by a bacterium called Mycobacterium tuberculosis. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. If not treated properly, TB disease can be fatal.
We **require** the 2 step PPD Screening Exam for all new admissions to the programs Two-step testing is useful for the initial skin testing of adults who are going to be retested periodically, such as health care workers or nursing home residents. This two-step approach can reduce the likelihood that a boosted reaction to a subsequent TST will be misinterpreted as a recent infection. (CDC, 2013).

If you have had a positive PPD in the past, or in the first step of the 2 step PPD Screening Exam, you must do TB blood testing with the T Spot or the QuantiFERON®-TB Gold. WE DO NOT ACCEPT CHEST XRAYS.

2 Step PPD Results

First PPD

Date of injection_____ (Have read in 48-72 hours)

_____mm induration _____positive (**get T spot TB Blood Test or QuantiFERON®-TB Gold**)

_____negative (get second step in 1 week)

_____ _____
Signature of Health Care Provider Reading Results Date

Second PPD

Date of injection_____ (Have read in 48-72 hours)

_____mm induration _____positive (get T spot TB Blood Test)

_____negative

_____ _____
Signature of Health Care Provider Reading Results Date

T spot TB Blood or QuantiFERON®-TB Gold Test (If Required due to Positive PPD)

Results_____

_____ _____
Signature of Health Care Provider Reading Results Date

Follow Up Tuberculosis Screening Verification Sheet
(This will be submitted 12 months after first Tuberculosis Screening)

Name_____Program_____

PPD screening is required every 12 months. After the initial 2 Step PPD Testing, follow up PPD testing will only require the first step. If a person had a positive PPD in the 2 step PPD, follow up will be a repeat of T Spot TB blood test. or the QuantiFERON®-TB Gold. WE DO NOT ACCEPT CHEST XRAYS.

It is up to the student to provide documentation to Certified Backgrounds each time you receive a PPD Screening or a new T Spot TB Blood or the QuantiFERON®-TB Gold Test Result. Failure to comply could result in removal from clinical setting per agency policies.

PPD

Date of injection_____ (Have read in 48-72 hours)

_____mm induration _____positive **get T spot TB Blood Test or QuantiFERON®-TB Gold**)

_____negative

_____ _____

Signature of Health Care Provider Reading Results Date

T spot TB Blood or QuantiFERON®-TB Gold Test (If Required due to Positive PPD)

Results_____

_____ _____

Signature of Health Care Provider Reading Results Date

Varicella (Chicken Pox) Immunization Verification Sheet

Name_____ Program_____

Varicella (chickenpox) is a highly contagious disease that is very uncomfortable and sometimes serious. The chickenpox vaccine is the best protection against chickenpox. The vaccine is made from weakened varicella virus that produces an immune response in your body that protects you against chickenpox. The chickenpox vaccine was licensed for use in the United States in 1995. Since then, the vaccine has become widely used. Thanks to the chickenpox vaccine, the number of people who get chickenpox each year as well as hospitalizations and deaths from chickenpox have gone down dramatically in the United States. (CDC, 2013)

Must complete both criteria one and two to comply with SNAH policy

Criteria One: Varicella Vaccine (Must be given at least one month after first dose)

Injection One_____
Date
Injection Two_____
Date_

Criteria Two: Serology for Varicella Antibody (copy of lab results must be submitted with form)

Date_____
_____Positive Immunity _____Negative Immunity

It is up to the student to provide documentation to Castlebranch each time you receive an injection. Failure to comply could result in removal from clinical setting per agency policies.

_____
Signature of Provider
(Must be signed by a licensed health care professional)

If you choose to not receive immunization, you must sign a waiver available in the offices of the School of Nursing and Allied Health.

COVID 19 IMMUNIZATION VERIFICATION SHEET

Name _____ Program _____

COVID-19 is a disease caused by a virus called SARS-CoV-2. Most people with COVID-19 have mild symptoms, but some people become severely ill. Older adults and people who have certain underlying medical conditions are more likely to get severely ill. Post-COVID conditions are a wide range of health problems people can experience four or more weeks after first getting COVID-19. Even those who do not become severely ill from COVID-19 may experience post-COVID conditions. COVID-19 vaccines available in the United States are effective at protecting people from getting seriously ill, being hospitalized, and even dying. As with vaccines for other diseases, people who are up to date are protected best. CDC recommends that everyone ages 5 years and older get their primary series of COVID-19 vaccine, and everyone ages 12 years and older also receive a booster shot. (CDC, 2022)

Must complete both criteria one and two to comply with SNAH policy

Criteria One: COVID 19 Vaccine

Required:

Injection One_____
Date
Injection Two_____
Date

Strongly Recommended:

Booster _____
Date

Criteria Two: Provide an upload of the actual vaccination card (front and back)

It is up to the student to provide documentation to Castlebranch each time you receive an injection.

Failure to comply could result in removal from clinical setting per agency policies.

_____

Signature of Provider
(Must be signed by a licensed health care professional)

If you choose to not receive immunization, you must sign a waiver available in the offices of the School of Nursing and Allied Health.