

**TN eCampus (formerly Regents Online Campus Collaborative)**  
**Master of Science in Nursing**  
**Health History and Physical Examination Form**

**HEALTH HISTORY – To be completed by student and/or health care provider – include immunization documentation and values.**

Name: \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Transgender \_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone# \_\_\_\_\_

In Emergency, Notify \_\_\_\_\_ Phone# \_\_\_\_\_

**PLEASE CHECK ( ) ANY OF THE FOLLOWING THAT YOU HAVE HAD IN THE PAST OR HAVE AT PRESENT:**

Allergy Specify _____	Frequent Colds	Hay Fever	Liver Disease
Arthritis	Depression	Frequent Headache	Nervousness
Artificial Joint	Diabetes	Heart Disease	Psychiatric Treatment
Asthma	Epilepsy/Seizures	Hemophilia	Stroke
Bone or Muscle Trouble	Eye Trouble	Hepatitis	Tuberculosis
Cancer	Fainting or Dizzy Spells	Kidney Trouble	Ulcers

Comment on all positive responses and any major illness, operations, injuries or other health problems:

\_\_\_\_\_  
 \_\_\_\_\_

Have you ever been hospitalized?    yes    no            If YES, for what, where and at what age?

\_\_\_\_\_

Do you currently take any medication on a regular or long-term basis?    yes    no

If YES, please specify \_\_\_\_\_

**MEDICAL EXAMINATION – To be completed by MD, NP, or PA**

Blood Pressure \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Eyes: Vision.....R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Hearing.....R \_\_\_\_\_ L \_\_\_\_\_

Glasses worn      yes      no

Hearing Aids      yes      no

Contacts            yes      no

List Positive Findings of Complete Medical Exam:

\_\_\_\_\_  
\_\_\_\_\_

Recommendations regarding treatment and correction: \_\_\_\_\_

Amy condition which may result in an emergency?      yes      no      If YES, specify \_\_\_\_\_

\_\_\_\_\_

List other health concerns that could interfere with learning: \_\_\_\_\_

\_\_\_\_\_

*Because the TBR seeks to provide in as much as possible a reasonably safe environment for its health career students and their patients, a student may be required, during the course of the program, to demonstrate his/her physical and/or emotional fitness to meet the essential requirements of the program. Such essential requirements may include the ability to perform certain physical tasks, and suitable emotional fitness. Any appraisal measures used to determine such physical and/or emotional fitness will be in compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, so as not to discriminate against any individual on the basis of disability.*

Is there a condition that may limit participation in?

A. Classroom activity?      yes      no

B. Clinical activity?      yes      no

If YES, specify: \_\_\_\_\_

\_\_\_\_\_

Comments and recommendations: \_\_\_\_\_

\_\_\_\_\_

*On the basis of this examination and mindful of the note above, in my opinion, the applicant is physically and mentally fit to participate in the nursing program.*

Date \_\_\_\_\_

Signature \_\_\_\_\_ MD or NP or PA

Phone number \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

IMMUNIZATIONS AND TESTS – To be completed by MD, NP or PA
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## Immunization Requirements

1. MMR/ (Measles, Mumps, Rubella) (Two doses at least 28 days apart)

Dose 1 MMR given at age 12 months or later– Date \_\_\_\_\_

Dose 2 given at least 28 days after first dose - Date \_\_\_\_\_

**OR** TITERS

Measles (Rubeola) titer result: Positive \_\_\_\_ Negative \_\_\_\_ Date \_\_\_\_\_

Mumps titer result: Positive \_\_\_\_ Negative \_\_\_\_ Date \_\_\_\_\_

Rubella titer result: Positive \_\_\_\_ Negative \_\_\_\_ Date \_\_\_\_\_

2. VARICELLA (Chicken Pox) – Must provide written documentation of Titer. If titer is negative student will be required to get two Varicella Vaccines given 28 days apart. A follow up titer is required.

Varicella titer result: Positive \_\_\_\_ Negative \_\_\_\_ Date of Titer \_\_\_\_\_

**IF NEGATIVE**, date of vaccinations:

Dose 1: \_\_\_\_\_ Dose 2: (give at least 4 weeks after dose 1): \_\_\_\_\_

3. Hepatitis B – Proof of immunity is required at completion of series.

Date of Hepatitis B Vaccines (Documentation Required)

#1 date \_\_\_\_\_ #2 date \_\_\_\_\_ #3 date \_\_\_\_\_

**AND TITER RESULTS:**

Hep BsAB titer result: Positive \_\_\_\_ Negative \_\_\_\_ Date of Titer \_\_\_\_\_

**Refused\***: Waiver signed Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Waiver \_\_\_\_\_

\*The Hepatitis B requirement cannot be approved unless you provide documentation of a positive titer result or you submit a completed and signed Hepatitis B Waiver Form (available on MSN RODP Website)

4. Tetanus – Tdap booster received in the past 10 years. **Must** provide written documentation.

Date of last Tdap booster \_\_\_\_\_

5. Tuberculin Tests:

INITIAL TWO-STEP TUBERCULIN SKIN TEST GIVEN ONE TO THREE WEEKS APART (If two-step is negative, one-step TB is required annually)

Date of 1<sup>st</sup> TB skin test: \_\_\_\_\_ Date Read: \_\_\_\_\_

Result: Positive: \_\_\_\_\_ Negative: \_\_\_\_\_

Date of 2<sup>nd</sup> TB skin test: \_\_\_\_\_ Date Read: \_\_\_\_\_

Result: Positive: \_\_\_\_\_ Negative: \_\_\_\_\_

**If positive:**Medical evaluation and documentation of a clear **chest x-ray** prior to admission to your clinical preceptorship and annual completion of the **Annual Past-Positive TB Screening Form** (available on TN eCampus website) confirming

the absence of symptoms by a MD or NP. If there is evidence of a positive chest x-ray and/or symptoms of TB, please follow-up for medical evaluation.

6. Influenza:

1 dose of TIV (trivalent) or LAIV (live attenuated) annual vaccination (highly recommended) OR signed **Influenza Waiver Form** (available on TN eCampus website) to decline seasonal flu vaccine. **Please note** - many clinical agencies are requiring evidence of annual vaccination or the wearing of a mask during flu season.

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*Date*

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*Signature of MD or NP*

## STUDENT AFFIRMATIONS – To be signed by the student and witness

**Core Performance Standards Required for Nursing**

Issue	Standard	Some Examples of Necessary Activities (not all inclusive)
Critical Thinking	Critical thinking ability sufficient for clinical judgment.	Identify cause and effect relationships in clinical situations, develop nursing care plans.
Interpersonal	Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.	Establish rapport with patients/clients and colleagues.
Communication	Communication abilities sufficient for interaction with others in verbal and written form.	Explain treatment procedures, initiate health teaching, document and interpret nursing actions and patient/client responses.
Mobility	Physical abilities sufficient to move from room to room and maneuver in small spaces	Moves around in patient's rooms, workspaces, and treatment areas, administer cardiopulmonary procedures.
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective nursing care.	Calibrate and use equipment; position patients/clients.
Hearing	Auditory ability sufficient to monitor and assess health needs.	Hears monitor alarm, emergency signals, auscultatory sounds, cries for help.
Visual	Visual ability sufficient for observation and assessment necessary in nursing care.	Observes patient/client responses.
Tactile	Tactile ability sufficient for physical assessment.	Perform palpation, functions of physical examination and/or those related to therapeutic intervention, e.g., insertions of catheter.

*I certify that I have reviewed the foregoing information supplied by me and my health care provider and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish my Home Campus a complete transcript of my medical record for purposes of determining my eligibility to participate in the nursing program. I understand that falsification of information will result in immediate dismissal.*

*I further understand that during the course of the program I will be required to demonstrate physical and emotional fitness to meet the essential requirements of the program. Such essential requirements may include the ability to perform certain physical tasks, and suitable emotional fitness. Any appraisal measures used to determine such physical and/or emotional fitness will be in compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, so as not to discriminate against any individual on the basis of disability.*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Student Signature*

\_\_\_\_\_

*Witness*

This completed form with all required documentations must be returned to the School of Nursing and uploaded into Medatrx by the announced deadline or you will not be allowed to register and/or participate in classes or clinical. Necessary treatments or corrections must be taken care of prior to beginning nursing courses. Enrollment in the nursing major is limited. Failure to comply with all health requirements will result in dismissal and your space will be offered to the next qualified alternate.

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*TBR is an equal opportunity, non-racially identifiable, educational institution that does not discriminate against individuals with disabilities.*