COLLEGE OF THE DESERT

Health Sciences/ECE Division
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PRE-ENTRANCE MEDICAL RECORD

(Please print)

APPLICANT:_____ **PROGRAM:**_____
(Last) (First) (Middle)

Dear Health Care Provider: Please document findings in the designated areas, then date and sign. Please provide student with copies of their lab results, as they will need to prove their immunity to the health care facilities in order to participate in the clinical experience.

TB

Two-step TB Test:	Test #1	Test #2	*Chest X-RAY (if +skin test):*
Date Read:			Date:
Result/initials:	/	/	Impression: ☐ normal ☐ abnormal

Free of communicable TB: ☐ **Yes** ☐ **No** **Signature of provider:**_____

***Evidence of Immunity to be documented by positive titer results:* ***

	Titer Result	*Immunization (if no immunity)*	
Mumps	Immunity: ☐ Yes ☐ No	Date: #1	#2
Rubella (german measles)	Immunity: ☐ Yes ☐ No	Date: #1	#2
Rubeola (measles)	Immunity: ☐ Yes ☐ No	Date: #1	#2
Varicella (chicken pox)	Immunity: ☐ Yes ☐ No	Date: #1	#2

Hepatitis B:

IMMUNIZATION		Immunity per **Titer:** Date:
Vaccination #1:	Date:	Hep B Surface Antigen ( ) Non reactive ( ) Reactive
Vaccination #2:	Date:	Hep B Surface Antibody ( ) Reactive ( ) Nonreactive
Vaccination #3:	Date:	Hep B Core Antigen ( ) Non reactive ( ) Reactive

Hepatitis C: Date: _____ Result: ( ) Nonreactive ( ) Reactive

I certify that I have reviewed the above results and that the applicant's titers indicate immunity to the above. In lieu of positive titer results, immunizations were given on date indicated.

Signature of provider:_____

Physical Examination:
I have taken a health history, and conducted a physical examination, including vision and hearing tests. I consider the applicant able to undertake a full time educational program in nursing or a related allied health field.

Remarks:_____

Health Care Provider: _____ ***Date:*** _____

Signature: _____

Address: _____

City:_____ ***State:***____ ***Zip:***_____ ***Phone:***_____

COD OFFICE STATUS OF REQUIREMENTS:

A. ☐ **All requirements are met Date: ____/____/_____ B.** ☐ **Currently up-to-date, but more doses due later. Follow up needed.**

COMMENTS:_____

_____

_____

Office/forms/medical.doc 4/00; rev 8/00; 5/03; 12/03; 3/04; 11/04; 10/05; 5/06

- # TITER CLARIFICATION:

1. **Initial two step tuberculin skin test (within past six months) with annual update or documentation as a positive reactor or a chest x-ray taken within the past 12 months.**

2. **Proof of Rubella and Measles immunity by positive antibody titers or two doses or MMR.**

3. **Varicella immunity by positive history of chicken pox or proof of varicella immunization.**

4. **Evidence of completion of Hepatitis B immunization series or completion of a certification of declination of vaccine.**