LAMAR STATE COLLEGE ORANGE
PHYSICAL EVALUATION FORM - MEDICAL HISTORY

This page of the Lamar State College Orange Physical Evaluation Form is to be completed in its entirety by the student.

LVN / RN (circle one)

Today's Date ____________ **LSCO Program of Study** ____________

Last Name ____________ **First Name** ____________ **Middle Initial** ____________

Date of Birth ____________ **Phone Number** ____________

Address ____________ **City / State** ____________ **Zip Code** ____________

Health History

Please indicate if you have or have had any of the following health problems.

	Disease or Symptom	✓		Disease or Symptom	✓		Disease or Symptom	✓
1	allergies		15	dental		29	malaria	
2	anemia		16	diabetes		30	measles (rubeola)	
3	anxiety		17	dizziness		31	monoucleosis (EBV)	
4	arthritis		18	drug (including alcohol) problem		32	mumps	
5	asthma		19	eating disorder		33	neurological disorder	
6	back problems		20	eye disease or injury		34	parasites	
7	blood disorder		21	frequent headaches		35	pneumonia	
8	bone or joint problem		22	german measles (rubella)		36	psychiatric illness	
9	cancer		23	GI disorders/ including hernia		37	scarlet fever	
10	cardiac problems		24	hepatitis (specify type)		38	sexually transmitted disease	
11	chicken pox (varicella)		25	high blood pressure		39	surgery (any)	
12	cholera		26	hospitalization (any)		40	syphillis	
13	chronic bronchitis		27	inflammatory bowel disease		41	tuberculosis	
14	depression		28	kidney disease		42	typhoid fever	

EXPLANATION OF ABOVE

SOCIAL HISTORY - please circle response

a. **Tobacco**: Smoking (**yes / no**) Oral/Chew/Spit (**yes / no**) **Amount & Frequency**: ____________

b. **Alcohol**: (**yes / no**) **Amount & Frequency**: ____________

c. **Exercise**: (**yes / no**) **Sport/Activity** ____________ **Frequency** ____________

d. **Seat Belt Use**: (**yes / no**) **If yes, what percentage of the time.** ____________

MEDICATIONS (Including prescribed, over-the-counter, and/or herbal)

a. ____________
b. ____________
c. ____________
d. ____________

Do you have any allergies to medications, food, or environmental sources? **(yes / no)** If yes, please describe

Are there any health problems in the immediate family? (parents or siblings) (**yes / no**) If yes, please describe

LAMAR STATE COLLEGE ORANGE
PHYSICAL EVALUATION FORM - MEDICAL HISTORY - Page 2

This page of the Lamar State College Orange Physical Evaluation Form is to be completed in its entirety by a physician, physician assistant or certified nurse practitioner. Physical exam results must be current within one year of any clinical experience.

Height: ________ **Weight:** ____________ **Sex (F / M)** **Resting Pulse** ______________________

Blood Pressure ____________ **Uncorrected Vision: R** ________ /20 **L** ______ /20
Corrected Vision: R ________ /20 **L** /20

Please examine and comment on the following syst ems.

		Normal	Abnormal (comment)
1.	Head, Eyes, Ears, Nose, and Throat		
2.	Respiratory		
3.	Cardiovascular		
4.	Gastrointestinal		
5.	Genito-urinary		
6.	Musculoskeletal		
7.	Metabolic/Endocrine		
8.	Neuropsychiatric		
9.	Skin		

LAB: Please include the results of any lab work that you routinely perform or feel is indicated. ______________________

1. For each of the Essential Functions listed below, please refer to the attached explanatory document and indicate whether the student is able toperform the task by checking the appropriate box.

Essential Function		Yes	No	If no, please comment.
1.	Sensory			
a.	Visual			
b.	Auditory			
c.	Tactile			
d.	Olfactory			
2.	Communication/Interpersonal Relationships			
3.	Cognitive/Critical Thinking			
4.	Motor Function			
5.	Professional Behavior			

2. Based on the findings in the examination, is the student able to participate in all activities required in the indicated health education program? **(Please circle appropriate response.)** **Yes** **No**
3. Please identify any restrictions to be placed on this student's participation in the indicated health education program?
4. Is this student free of infectious disease? **(Please circle appropriate response.)** **Yes** **No**

General Comments: ______________________________

HEALTHCARE PROIVDER SIGNATURE: The information on this form must be filled in and signed by a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nursing. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type): ______________________ **Date of Examination:** ____________
Address: ______________________
Phone Number: ______________________
Signature: ______________________

Signature of Student verifying that the information on the front and back of this Lamar State College-Orange Physical Evaluation Form is accurate.

Signed: ______________________ **Date:** ____________

LAMAR STATE COLLEGE ORANGE
NURSING PROGRAMS
ESSENTIAL FUNCTIONS

Lamar State College Orange (LSCO) endorses the Americans' with Disabilities Act. In accordance with College policy, when requested, reasonable accommodations may be provided for individuals with disabilities.

Physical, cognitive, psychomotor, and affective abilities are required in unique combinations to provide safe and effective patient care. The applicant /student must be able to meet the essential functions with or without reasonable accommodations throughout the program of learning. Admission, progression and graduation are contingent upon one's ability to demonstrate the essential functions delineated for the allied health programs with or without reasonable accommodations. The allied health programs and/or the affiliated clinical agencies may identify additional essential functions. The allied health programs reserve the right to amend the essential functions as deemed necessary.

To be admitted and to progress in an allied health program one must possess a functional level of ability to perform the duties required of a health care provider. Admission or progression may be denied if a student is unable to demonstrate the essential functions with or without reasonable accommodations.

The essential functions delineated are those deemed necessary the LSCO allied health programs. No representation regarding industrial standards is implied. Similarly, any reasonable accommodations made will be determined and applied to the respective allied health program and may vary from reasonable accommodations made by healthcare employers.

The essential functions delineated below are necessary for allied health program admission, progression and graduation and for the provision of safe and effective patient care. The essential functions include but are not limited to the ability to:

1) Sensory Perception
   a) Visual
      i) Observe and discern subtle changes in physical conditions and the environment
      ii) Visualize different color spectrums and color changes
      iii) Read fine print in varying levels of light
      iv) Read for prolonged periods of time
      v) Read cursive writing
      vi) Read at varying distances
      vii) Read data/information displayed on monitors /equipment
   b) Auditory
      i) Interpret monitoring devices
      ii) Distinguish muffled sounds heard through a stethoscope
      iii) Hear and discriminate high and low frequency sounds produced by the body and the environment
      iv) Effectively hear to communicate with others
   c) Tactile
      i) Discern tremors, vibrations, pulses, textures, temperature, shapes, size, location and other physical characteristics
   d) Olfactory
      i) Detect body odors and odors in the environment

2) Communication/ Interpersonal Relationships
   a) Verbally and in writing, engage in a two-way communication and interact effectively with others, from a variety of social, emotional, cultural and intellectual backgrounds
   b) Work effectively in groups
   c) Work effectively independently
   d) Discern and interpret nonverbal communication
   e) Express one's ideas and feelings clearly
   f) Communicate with others accurately in a timely manner
   g) Obtain communications from a computer

3) Cognitive/Critical Thinking
   a) Effectively read, write and comprehend the English language
   b) Consistently and dependably engage in the process of critical in order to formulate and implement safe and ethical nursing decisions in a variety of health care settings
   c) Demonstrate satisfactory performance on written examinations including mathematical computations without a calculator
   d) Satisfactorily achieve the program objectives

4) Motor Function
   a) Handle small delicate equipment/objects without extraneous movement, contamination or destruction
   b) Move, position, turn, transfer, assist with lifting or lift and carry clients without injury to clients, self or others

c) Maintain balance from any position
d) Stand on both legs
e) Coordinate hand/eye movements
f) Push/ pull heavy objects without injury to client, self or others
g) Stand, bend, walk and/or sit for 6-12 hours in a clinical setting performing physical activities requiring energy without jeopardizing the safety of the client, self or others
h) Walk without a cane, walker or crutches
i) Function with hands free for nursing care and transporting items
j) Transport self and/or client without the use of electrical
k) Flex, abduct and rotate all joints freely
l) Respond rapidly to emergency situations
m) Maneuver in small areas
n) Perform daily care functions for the client
o). Coordinate fine and gross motor hand movements to provide safe effective nursing care
p) Calibrate/use equipment
q) Execute movement required to provide nursing care in all health care settings
r) Perform CPR and physical assessment
s) Operate a computer

5) Professional Behavior
a) Convey caring, respect, sensitivity, tact, compassion, empathy, tolerance and a healthy attitude toward others
b) Demonstrate a mentally healthy attitude that is age appropriate in relationship to the client
c) Handle multiple tasks concurrently
d) Perform safe, effective nursing care for clients in a caring context
e) Understand and follow the policies and procedures of the College and clinical agencies
f) Understand the consequences of violating the student code of conduct
g) Understand that posing a direct threat to others is unacceptable and subjects one to discipline
h) Meet qualifications for licensure by examination as stipulated by the Texas Board of Nurse Examiners
i) Not to pose a threat to self or others
j) Function effectively in situations of uncertainty and stress inherent in providing nursing care
k) Adapt to changing environments and situations
I) Remain free of chemical dependency /
m) Report promptly to clinical and remain for 6-12 hours on the clinical unit
n) Provide nursing care in an appropriate time frame
o) Accepts responsibility, accountability, and ownership of one's actions
p) Seek supervision/consultation in a timely manner
q) Examine and modify one's own behavior when it interferes with nursing care or learning

Upon admission, an individual who discloses a disability can request reasonable accommodations. Individuals will be asked to provide documentation of the disability in order to assist with the provision of appropriate reasonable accommodations. LSCO will provide reasonable accommodations but is not required to substantially alter the requirements or nature of a program. To be admitted one must be able to perform all of the essential functions with or without reasonable accommodations. If an individual's health changes during the program of learning, so that the essential functions cannot be met with or without reasonable accommodations, the student will be withdrawn from the allied health program. The allied health faculty reserves the right at any time to require an additional medical examination at the student's expense in order to assist with the evaluation of the student's ability to perform the essential functions. Requests for reasonable accommodations should be directed to the LSCO Special Population Coordinator at 409-882-3955 or https://www.lsco.edu/advising/disability.asp.

Lamar State College Orange

Nursing Department

Immunizations Required by State Law/Clinical Facilities

COPIES OF IMMUNIZATION CARDS ARE ACCEPTABLE

Name: ______________________________ **Date of Birth:** ______________________

Measles (Rubeola)*:	
A. Two doses of measles vaccine on or after their first birthday and at least 30 days apart **(**See note) OR**	**Date # 1** ____________ (mm/dd/yy) **Date # 2** ____________ (mm/dd/yy)
B. Serologic test positive for measles antibody *****See note**	**Date:** ____________ (mm/dd/yy) **Result:** ____________
Mumps*:	
A. Two doses of mumps vaccine on or after their first birthday **OR**	**Date # 1** ____________ (mm/dd/yy) **Date # 2** ____________ (mm/dd/yy)
B. Serologic test positive for mumps antibody *****See note**	**Date:** ____________ (mm/dd/yy) **Result:** ____________
Rubella*:	
A. One does of Rubella vaccine on or after their first birthday **OR**	**Date:** ____________ (mm/dd/yy)
B. Serologic test positive for Rubella antibody ***** See note**	**Date:** ____________ (mm/dd/yy) **Result:** ____________

***Measles, Mumps, Rubella (MMR)/Varicella vaccines if not given on same day MUST be 30 days apart.**

****Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible.**

*****Must be the date of diagnosis or test collection; not when primary care provider signed immunization form.**

Hepatitis B (HVB Series) must show proof of:	
A. Give 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2.) **If a student does not follow the afore-mentioned guidelines when receiving the 3-dose series, the student may need to submit to a serologic test. ***** See note**	**Date # 1** ____________ (mm/dd/yy) **Date # 2** ____________ (mm/dd/yy) **Date # 3** ____________ (mm/dd/yy)
B. Serologic test positive for Hepatitis B antibody ***** See note**	**Date:** ____________ (mm/dd/yy) **Result:** ____________

*****Must be the date of diagnosis or test collection; not when primary care provider signed immunization form.**

*******If anti-HBs is at least 10mIU/mL (positive), the patient is immune. No further serologic testing or vaccination is recommended.**

If anti-HBs is less than 10 mIU/mL (negative), the patient is unprotected from hepatitis B virus (HBV) infection; revaccinate with a 3-dose series. Retest anti-HBs 1-2 months after dose #3. If anti-HBs is positive, the patient is immune. No further testing or vaccination is recommended. If anti-HBs is negative after 6 doses of vaccine, patient is a non-responder.

Name: ______________________________ **Date of Birth:** ____________________

Varicella* **must show proof of:**	
A. Two doses of varicella vaccine on or after their first birthday and at least 30 days apart ****** OR**	**Date # 1** __________ (mm/dd/yy) **Date # 2** __________ (mm/dd/yy)
B. Serologic test positive for Varicella antibody **OR ***See note**	**Date:** __________ (mm/dd/yy) **Result:** __________
C. Physician documented history or diagnosis of Varicella ***** See note**	**Date Disease Occurred** __________ (mm/dd/yy) **Documented history after September 1, 1991 must have a month, day, and year.**

***Measles, Mumps, Rubella (MMR)/Varicella vaccines if not given on same day MUST be 30 days apart.**
*****Must be the date of diagnosis or test collection; not when primary care provider signed immunization form.**
******Only one dose of Varicella vaccine is needed if the student received first dose before the age of thirteen (13).**

New Requirement: Proof of Pertussis is now required by clinical affiliates.

Tdap	
Vaccine required once only: Note: Tdap booster every 10 years.	**Date** __________ (mm/dd/yy)

Tb Skin Test - Required Annually	
Tb Skin Test Administered	**Date (mm/dd/yy):** __________
Tb Skin Test **Results & Date Read (mm/dd/yy)**	**Q Positive**_____**mm Q Negative**_____**mm Date** _____
Chest X-ray (required **IF** skin test positive) Must provide signed documentation of results	**X-ray results:** __________ **Date (mm/dd/yy):** __________

Seasonal Flu Shot (Taken after October 1)	**Date** __________ **(mm/dd/yy)**

Physician or Approved Licensed Health Professional Information:

Printed Name ______________________________

Address ______________________________

Signature of Primary Care Provider% ______________________________

Date : ______________________________

% - Validates all information on page one and two of the Immunizations Required by State Law/Clinical Facilities form.
Date of signature must be after last immunization or additional immunizations must be signed and dated separately.

+Vaccines administered after September 1, 1991, shall include the MM/DD/YY each vaccine was given.

NOTE: Students will be required to get a seasonal flu shot.