



# VIRGINIA PENINSULA COMMUNITY COLLEGE

## Preadmission Health History and Physical Exam Forms for VPCC Allied Health Programs

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**INSTRUCTIONS TO STUDENT:** This form must be filled out by student and a licensed primary care provider: physician, physician assistant, or nurse practitioner after official acceptance to a NOVA Health Sciences program. Physical examinations must be completed and are required prior to placement in the clinical portion of the program. Upon completion, the student will keep the original, and submit a copy to the CastleBranch tracker.

**PART I** Student: Complete this section before visiting primary care provider. Please print.

Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
Street City/State Zip Code

Student ID: \_\_\_\_\_

Telephone: \_\_\_\_\_  
Home Work Cell

Birthdate: \_\_\_\_\_  
Month Day Year

E-mail Address: \_\_\_\_\_@email.vccs.edu \_\_\_\_\_  
College Other E-mail Address

**NOTE:** The student is required to maintain health insurance and/or be responsible for medical expenses incurred during a clinical rotation. Final placement in the clinical portion of your program is contingent on successful academic standing (didactic, lab, simulation, and program required skills), completion and passing of your drug screen, background check, and physical examination.

**PART II**

Instructions: This physical examination must be completed by a primary care provider and an OFFICIAL STAMP affixed on the following page. It includes the measurable Essential Functions/Technical Standards required to successfully practice in the health professions

1. Communication  
Essential Function/Technical Standard: Communicate in English, both verbally and in writing
2. Height \_\_\_\_\_
3. Weight \_\_\_\_\_
4. T:\_\_\_ P:\_\_\_\_\_ R:\_\_\_ BP:\_\_\_\_\_ \_ \_ \_ \_ \_
5. Vision: OD\_\_\_ OS\_\_\_\_\_OU\_\_\_\_\_ Corrected? \_\_\_ Yes No  
Essential Function/Technical Standard: Visual ability sufficient to observe patient/client responses
6. General Appearance: \_\_\_\_\_  
\_\_\_\_\_
7. Ears: \_\_\_\_\_  
Essential Function/Technical Standard: Hearing ability sufficient to monitor and assess health needs
8. Nose: \_\_\_\_\_  
Essential Function/Technical Standard: Smell sufficient to maintain patients' and environment safety
9. Throat \_\_\_\_\_
10. Neck: \_\_\_\_\_
11. Breasts: \_\_\_\_\_
12. Chest \_\_\_\_\_
13. Cardiovascular system: \_\_\_\_\_
14. Abdomen: \_\_\_\_\_
15. GI system: \_\_\_\_\_
16. GU system: \_\_\_\_\_
17. CNS/Reflexes: \_\_\_\_\_  
Essential Function/Technical Standard: Gross and fine motor skill abilities
18. Back: \_\_\_\_\_  
Essential Function/Technical Standard: Mobility to stand; sit; squat; turn; bend; lift
19. Extremities: \_\_\_\_\_  
Essential Function/Technical Standard: Tactile (touch) ability sufficient for assessment related to therapeutic intervention
20. Describe any conditions currently being treated: \_\_\_\_\_
21. Allergies:

Drugs	Medical Supplies i.e. Latex	Other i.e. Food/Seasonal

Primary Care provider:

I have this date given \_\_\_\_\_ a careful physical examination.  
Name of Student

Upon completion of this examination I believe to the best of my knowledge this applicant meets the measurable functions/standards without reasonable accommodations.

Printed name of Primary Care Provider

Signature of Primary Care Provider

Date

STATEMENT FOR STUDENTS REQUESTING ACCOMMODATIONS

Or

I have this date given \_\_\_\_\_ a careful physical examination  
Name of Student

Upon completion of this examination I believe to the best of my knowledge this applicant can meet the measurable functions/standards with certain reasonable accommodations. Based on my evaluation, this student will need the following reasonable accommodations:

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

Printed name of Primary Care Provider

Signature of Primary Care Provider

Date

STATEMENT FOR STUDENTS REQUESTING ACCOMMODATIONS

Please Print Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Telephone: \_\_\_\_\_

Official Stamp \_\_\_\_\_

### PART III Immunization Record Requirements

Immunizations must be documented/completed by a primary care provider. This form and all lab results must be scanned to the immunization tracker at the following address: <https://www.castlebranch.com>. Students will receive instructions on how to submit results to the immunization tracker after official acceptance to the program.

1	Measles, Mumps, Rubella (MMR)	One of the following is required: Two vaccinations OR positive antibody titer for all three components (lab report required). If series is in progress submit 1st vaccine and a new alert from CastleBranch will be created for you to complete the series. If any titer is negative or equivocal, a new alert will be created for you to receive one booster shot.	MMR-2 Vaccinations or one titer/booster: <b>D</b> ate of MMR 1 _____ <b>D</b> ate of MMR 2 _____ or <b>D</b> ate of TITER _____ If titer is negative or equivocal, student must receive a booster shot. <b>D</b> ate of Booster _____
2	Varicella <i>Chicken Pox</i>	One of the following is required: Two vaccinations OR positive antibody titer (lab report required) If series is in progress submit 1st vaccine and a new alert from CastleBranch will be created for you to complete the series. If any titer is negative or equivocal, a new alert will be created for you to receive one booster shot.	VARICELLA-2 Vaccinations or one titer <b>D</b> ate of Varicella 1 _____ <b>D</b> ate of Varicella 2 _____ or <b>D</b> ate of TITER _____ <b>I</b> titer is <i>negative</i> or <i>equivocal</i> , student must receive a booster shot. <b>D</b> ate of Booster _____
3	Hepatitis B	One of the following is required: three vaccinations OR a positive antibody titer (lab report required) OR declination waiver. If series is in progress, submit to CastleBranch where you are in the series and new alerts will be created for you to complete the series. If the titer is negative or equivocal, a new alert will be created for you to receive one booster shot.	HEPATITIS B- Series in progress or titer or declination <b>D</b> ate of Hepatitis B-1 _____ <b>D</b> ate of Hepatitis B- 2 _____ <b>D</b> ate of Hepatitis B- 3 _____ or <b>D</b> ate of TITER _____ or <b>D</b> ate of Declination form _____ <b>I</b> titer is <i>negative</i> or <i>equivocal</i> , student must receive a booster shot. <b>D</b> ate of Booster _____
4	Tuberculosis Skin Test (TST)	One of the following is required: Two- step TST skin test (1 to 3 weeks apart) OR QuantiFERON Gold blood test OR if positive results, provide clear Chest X-Ray results. Applicant must undergo annual TST testing to continue in health sciences programs.	TB requirement <b>D</b> ate and final result of Two-step TB test _____ or <b>D</b> ate and <i>negative</i> result of QuantiFERON Gold blood test _____ <b>D</b> ate and <i>negative</i> result of chest x-ray _____
5	Tetanus, Diphtheria, & Pertussis (Tdap)	Submit documentation of a Tdap booster within the past ten years OR Td booster within the past two years. The renewal date will be set for ten years if Tdap is submitted or two years if Td is submitted.	<b>D</b> ate of Tdap booster in the past ten years _____ or <b>D</b> ate of Td booster in the past two years _____
6	Influenza	The following will be required during the current flu season: Documentation of annual flu shot. The renewal date will be set for one year from administered date of vaccine.	See Program Director for date requirements for specific programs.
7	COVID-19	Submit documentation of a completion of the COVID-19 vaccine.	<b>D</b> ate of First Dose _____ <b>D</b> ate of Second Dose (if required) _____ or <b>D</b> ate of Declination form _____