

NURSING REQUIREMENTS must be submitted on **THE FIRST DAY OF CLASS** so students may receive clearance from our various clinical facilities. These DO NOT have to all be obtained at a single agency. Existing shot records can be taken to the health department to obtain a **Form 121 (Certificate of Immunization Compliance)** as required or you may get this from your primary healthcare provider.

Student MUST provide documentation of each of the following (please use this check list):

- **TDAP:** Proof of TDAP within last 10 YEARS regardless of when the last Td received. **Must be on Form 121.**
- **COVID-19:** Proof of two Pfizer vaccines, two Moderna vaccines, or one Johnson & Johnson vaccine (per clinical facility guidelines). Make a copy of your CDC COVID-19 Vaccination Record Card. NO EXEMPTIONS OR EXCEPTIONS will be accepted per clinical facility guidelines.
- **MMR:** Proof of TWO (2) MMR vaccines OR antibody titers* (blood test) proving immunity to Mumps, Rubella, AND Rubeola. Titers* must be a quantitative, numerical result, IgG test. If MMR vaccines are required, there must be at least 4 weeks between the first and second vaccine. **Must be on Form 121.**
- **VARICELLA:** Proof of TWO (2) Varicella (chicken pox) vaccines OR titer* proving immunity to Varicella. Titer* must be a quantitative, numerical result, IgG test. If Varicella vaccines are required, there must be at least 4 weeks between the first and second vaccine. **Must be on Form 121.**
- **HEP B (3 dose series):** Proof of the first TWO (2) doses of Hepatitis B vaccines is required before entering into the program. The 3rd dose must be completed prior to the 2nd semester of RN program. A quantitative titer* proving immunity is acceptable. **Must be on Form 121.**
- **TB TESTING:** Proof of **either** one (1) IGRA (Interferon Gamma Release Assay) test showing positive or negative for TB, **or** a two-step TB skin test/PPD** with documentation. **Step 1:** TB skin test administered and then student returns to facility which administered the test between 48 and 72 hours after administration for the test result to be read. Then **Step 2:** A second TB skin test is administered and then the student returns to the facility which administered the test between 48 and 72 hours after administration. **Note: Step 2** must be at least 7 days after Step 1's test result has been **read** but **not more than 21 days** after Step 1's test has been read. [Example: student receives TB skin test at primary care office on June 3rd. Student must return to same office on June 5 or June 6 to have result read. Then between 7 and 21 days later (June 12 or 13 through June 26 or 27, depending on date the first test was read) the student returns to primary care office to have second TB test administered. Then the student must return 48-72 hours after that date to have the second skin test read.]

Use the TB #1 and TB #2 forms (found on NWCC website) and be sure the healthcare provider fully and accurately completes each form.

****NOTE-The 2-step TB skin test will require you to visit the facility (which provides the test) a total of four (4) times.**

If the IGRA or step 1 or step 2 comes back positive, then you must show proof of the positive test AND have a chest X ray to prove you do not have active TB AND complete the "absence of TB symptoms" form (found on NWCC website).

Students do **NOT** need to complete the “absence of TB symptoms” form unless they have a **POSITIVE** result.

- **PHYSICAL EXAM:** Must be completed within the past 12 months on NWCC form (found on NWCC website). Health care provider must print name, sign form, and CIRCLE section of capability of providing safe care. (Expires in 2 years) Documentation on the Health Form must have the same dates on the front and the back of the form. (Healthcare provider completes and dates one side of form, and student completes and dates the other side of form using same date as HCP.)
- **CURRENT CPR certification:** MUST be American Heart Association Basic Life Support Provider. On-line courses without a return demonstration component are NOT acceptable. Student must turn in a copy of the actual AHA BLS card (copy of front and back) or a copy of the AHA BLS eCard.
- **FLU VACCINE:** Students entering fall semester should **NOT** get this vaccine until October. Proof of current season Quadrivalent Flu Vaccine **MUST** be on Northwest Flu Vaccine form (on NWCC website) and include all information on the form. Be sure provider will document on this form BEFORE obtaining vaccine. Students entering in spring semester must have received flu vaccine on or after October 1.

Pregnancy or breastfeeding will not be an exception. Students who are unable to provide proof of all vaccinations due to pregnancy or breastfeeding will need to withdraw from the course. After proof is obtained, the student will be allowed to re-enter the program in the next semester. All pregnant students must have a signed release from the health care provider to participate in lab and clinical experiences (forms found on NWCC website).

***TITERS:** If a titer is drawn and used as proof of immunity, student **MUST** include a separate copy (other than Form 121) and it must show the student’s numerical blood titer value, positive or negative, and include the lab’s reference range with guide to determine results.

MMR, Varicella, HepB vaccines do not “expire” so it does not matter how long ago you received them.

All information above must have the date and name of facility where testing/services were received and each form must be entirely complete. If there is a space for a healthcare provider signature, then it **MUST** be signed to be complete. It is the student’s responsibility to make sure these are completed in a timely manner. **Failure to comply with the requirements for clinical clearance will result in the student withdrawing from the course as the student will be unable to attend and participate in the required clinical portion of the course.**

All NWCC forms may be found on the NWCC website on the Department of Nursing page.

ALL NURSING REQUIREMENTS are due on the first day of class. You **MUST MAKE COPIES** of everything you turn in as these will **NOT** be returned to you. You **WILL** need copies of each of these again, so we advise you to go ahead and make at least two (2) copies—one to turn in and one to keep in a safe place (you will need these for an assignment and also may need to provide them for the next semester).

For questions, please contact the NWCC Nursing Department health requirements advisor Mrs. Beaver at rbeaver@northwestms.edu or the Nursing office at 662-562-3283.

**NORTHWEST MISSISSIPPI COMMUNITY COLLEGE
SCHOOL OF HEALTH SCIENCE
STUDENT HEALTH RECORD**

Student Name: _____ Sex: _____ DOB: _____

Last 6 digits of SS#: _____ Age: _____ Phone #: _____

Emergency contact: _____ Phone #: _____ Relationship: _____

I understand that all information is strictly confidential. I certify that the information given on this form is true and correct, and I have no abnormality, limitation, or restriction not mentioned on this document. I understand that any false information or failure to disclose any requested information will constitute grounds for dismissal from the nursing program. I agree to notify NWCC School of Health Science of any change in my physical or mental health prior to my registration and while I am a student in the Registered Nursing Program. I understand that I may be exposed to patient's bodily fluids and other hazardous material in the clinical setting. I can tolerate physically taxing workloads and function effectively under stress. I feel that I possess the emotional well-being required for the full use of intellectual abilities; the exercise of sound judgment, the prompt completion of all responsibilities attendant to the care of patients, the development of mature, sensitive, and effective relationships with clients, peers, and staff. I understand that I will be required to administer narcotics safely. I acknowledge by my signature that I have read and understand these statements and agree to be bound by them. I give my permission for release of all medical information related to this health form.

Date

Student Signature

*This section is to be completed by a physician or certified nurse practitioner **ONLY**.

HT _____ WT _____ B/P _____ PULSE _____ TEMP _____ RESP _____

HEENT _____

RESP _____ CV _____

GI/GU _____ MUSCULOSKELETAL _____

NEURO _____ LYMPH _____

Student Name: _____ Sex: _____ DOB: _____

In your opinion, is the applicant physically and mentally capable of providing safe client care with regard to the following functions? (circle one) YES NO

If NO, please explain:

All nursing applicants and current nursing students must possess the following essential functions:

- **Visual acuity** with corrective lenses to identify cyanosis, absence of respiratory movement in patients, read very fine, small print on medication, containers, physician orders, monitors and equipment calibrations. Must possess normal night, color and peripheral vision.

- **Hearing ability** (with auditory aids if necessary) to understand the normal speaking voice without viewing the speaker's face, hear monitor alarms, emergency signals, call bells from clients, and telephone orders; take/hear blood pressure, heart, lung, vascular and abdominal sounds with a stethoscope.

- **Physical ability** to stand for prolonged periods of time, perform cardiopulmonary resuscitation, lift patients/objects of 35 pounds or less without assistance, and move from room to room or maneuver in limited spaces. Must also be able to transfer and transport patients, sit in one place, kneel, reach and bend.

- **Effective communication skills** in verbal and written form by speaking clearly and succinctly when explaining treatment procedures, describing patient conditions and implementing health teaching. Write legibly and correctly in patient's chart for legal documentation.

- **Manual dexterity** to use sterile technique to insert catheters, withdraw blood and prepare medications (IV, PO, IM). Must also be able to perform repetitive hand and wrist motion, grip, squeeze and possess good hand/eye coordination.

DATE

PRINTED NAME OF MD/NP

SIGNATURE OF MD/ NP

PRINTED ADDRESS AND PHONE NUMBER OF MD/NP OR USE STAMP:

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ABSENCE OF TUBERCULOSIS SYMPTOMS FORM

1. Have you ever had a history of a positive Mantoux (PPD, TST)? YES NO
2. Have you ever had a BCG Tuberculosis Vaccination? YES NO
3. When was your last chest x-ray? Date: _____
4. Have you had a persistent cough for more than 3 weeks? YES NO
5. Have you had any blood in your sputum? YES NO
6. Do you have pain in your chest when you cough? YES NO
7. Have you recently had a respiratory illness that did not respond to treatment? YES NO
8. Have you had an unexplained fever in the past 3-6 weeks? YES NO
9. Have you experienced any unintentional or unexplained weight loss? YES NO
10. Have you experienced any night sweats? YES NO
11. Have you experienced unexplained increased lethargy or fatigue? YES NO
12. Have you experienced an unexplained loss of appetite? YES NO
13. Have you been in close contact with an individual with known active tuberculosis? YES NO

Comments (Explain any YES answers above)

Results:

No signs or symptoms of tuberculosis present.

Signs and symptoms of tuberculosis present. Follow-up with Primary Care Provider required.

Health Provider's Signature: _____

Title: _____ Date: _____

Clinic Address: _____ Clinic Name: _____

Student Name: _____

Exam Date: _____



NORTHWEST
MISSISSIPPI COMMUNITY COLLEGE
DEPARTMENT OF NURSING

Tuberculin Skin Test #1 Documentation

Name: _____

Date & Time PPD Placed: _____ Right Arm ___ Left Arm ___

Lot Number of Vaccine: _____ Expiration Date: _____

Manufacturer: _____

Administered by: _____ Are you certified? Yes ___ No ___

Date PPD Read: _____ Induration _____ MM

Read by: _____ Are you certified? Yes ___ No ___

Tuberculin skin test is: Negative ___ Positive ___

Referred for chest x-ray: Yes ___ No ___

If unable to take TB Skin Test, complete interferon-gamma release assay test for TB.

Place health care provider/health care facility stamp below:

(If stamp is not available, health care provider, please print name and address, and provide signature.)

Name: _____

Address: _____

Phone Number: _____

Signature: _____



NORTHWEST
MISSISSIPPI COMMUNITY COLLEGE
DEPARTMENT OF NURSING

Tuberculin Skin Test #2 Documentation

Name: _____

Date & Time PPD Placed: _____ Right Arm ___ Left Arm ___

Lot Number of Vaccine: _____ Expiration Date: _____

Manufacturer: _____

Administered by: _____ Are you certified? Yes ___ No ___

Date PPD Read: _____ Induration _____ MM

Read by: _____ Are you certified? Yes ___ No ___

Tuberculin skin test is: Negative ___ Positive ___

Referred for chest x-ray: Yes ___ No ___

If unable to take TB Skin Test, complete interferon-gamma release assay test for TB.

Place health care provider/health care facility stamp below:
(If stamp is not available, health care provider, please print name and address, and provide signature.)

Name: _____

Address: _____

Phone Number: _____

Signature: _____

Rev. 11/19

4975 Highway 51 North, Senatobia, MS 38668
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Fingerprinting Info

Per clinical guidelines, you will be fingerprinted prior to the first day of class. The Department of Nursing will notify you of this date soon. Refer to the NWCC bulletin for further information.



CPR Certification

CPR certification MUST be American Heart Association Basic Life Support

(AHA HeartSaver, Red Cross or Lifeguarding courses are NOT acceptable)

****Courses that do not include hands-on training will not be accepted****

If you already have CPR certification, bring your card with you to your pre-registration appointment for review to ensure it meets clinical facility requirements.

If you need CPR certification, AHA Basic Life Support classes will be taught for nursing students each May, November and December.

CPR certification is required while enrolled in the nursing program.

Cost: \$45.00 (Cash or Money Order ONLY!)

Make Money Order Payable to Stacy Taylor.

Sign up with Ms. Taylor for a date and time during your pre-registration appointment.

Bring your money order or cash with you.

For questions, please contact Ms. Taylor at 662-562-3982 or swtaylor@northwestms.edu.

**** Money is non-refundable after your spot has been secured. If you do not attend your class, you will have to make payment again for another class as space permits.**

NWCC Student Nurses' Association (SNA) Welcomes You!



SNA is an NWCC student organization in which all ADN students are required to maintain membership. We embrace "Nursing With Compassion for Community".

Some of our community service events and activities include (but are not limited to):

- Host "Special Activities" for all nursing students
- Collect needed items and/or funds for local and area organizations
 - Sponsor variety of community service projects
 - Participate in community health fairs/health education
 - Support NWCC events, such as homecoming activities
 - Sponsor student nursing contests with great prizes
- Enter state competitions at annual nursing student convention
 - And Much, Much, More!

**Dues are \$22...bring cash or money order (payable to "SNA")
to your registration appointment!**

*Dues include membership to both NWCC SNA and the Mississippi Organization for Student Nurses (MOSA).

Abbreviation	Meaning	Abbreviation	Meaning
a or ā	Before	NPO	Nothing by mouth
ac or AC	Before meals	NS	Normal saline
Ad lib	As needed	OTC	Over the counter
AM or am	Morning	Oz	Ounce
amp	Ampule	̄	After
bid	Twice a day	pc or PC	After meals
BP or B/P	Blood pressure	PEG	Percutaneousendoscopic Gastrostomy (tube in stomach)
bpm	Beats per minue	PCA	Patient-controlled analgesia
C	Celsius/Centlgrade	PO	By mouth
̄	With	PRN	When necessary
Cap or caps	Capsule	PM	Afternoon/Evening
d	Day	q	Every/ each
D ₅	IV containing Dextrose	qh	Every hour
D/C	discontinue	Q1h, Q2h	Every 1 hour/ every 2 hours
Elix	elixir	qs	Quantity sufficient
F	Fahrenheit	RR	Respiratory rate
g	Gram	Rx	Prescription
gr	Grain	̄	Without
gtt	Drop	SL	Sublingual/beneath tongue
GT	Gstrostomy tube	SR	Sustained or suspended release
h or hr	Hour	sol/soln	Solution
HR	Heart rate	Stat	immediately
ID	Intradermal	Subcut/SC/subQ/SQ	subcutaneously
IM	intramuscular	Supp	suppository
IV	intravenous	Tab/tabs	tablets
IVF	intravenous fluid	Tbsp/T	tablespoon
IVPB	intavenous piggyback	Tsp/t	teaspoon
IVP	Intravenous push	Temp	temperature
kg	Kilogram	Tid	three times a day
L	Liter		
lb	Pound	TKO/KVO	to keep open. Keep vein open
		TO	telephone order
MAR	Medication administration record	TPN	total perantral nutrition
mcg	Microgram	TPR	temperature/pulse/respiration
MDI	Metered dose inhaler	VO	verbal order
mEq	milliequivalent	XL	long acting
mg	milligram	XR	extended release
min	minute		
mL	milliliter	Symbol	Meaning
NG/NGT	Nasogastric tube	Δ	change
NKA	No known allergies	< >	less than/ greater than
NKDA	No known drug allergies	↑ ↓	increase/decrease