COLLEGE OF THE REDWOODS NURSING & HEALTHCARE PATHWAYS
PHYSICAL REQUIREMENTS FOR ALLIED HEALTH PROGRAMS

1. **Standing/Walking** – 75-95% of workday spend standing/walking on carpet, tile, linoleum, asphalt and cement while providing and managing client care, gathering client supplies and medications, obtaining and returning equipment. Approximate distance: 3-5 miles.

2. **Sitting**: 5-25% of workday spent sitting while communicating with and teaching clients, operating computers, answering the telephone, writing reports, documenting, calling doctors, and scheduling appointments.

3. **Lifting**: 10-15% of workday spent floor to knee, knee to waist, waist to waist and waist to shoulder level lifting while handling supplies (5 lbs.-20-30 times per shift), using trays (5-10 lbs.), and assisting with positioning patients in bed/moving patients on and off gurneys and exam tables (average weight 200 lbs.).

4. **Carrying**: 65% of workday spent carrying at waist level.

5. **Pushing/Pulling**: 40% of workday spent pushing/pulling, using carts, utilizing crash carts, opening and closing doors, pushing/pulling beds, gurneys, wheelchairs, and moving equipment and furniture.

6. **Climbing**: 15-25% of workday spent climbing stairs going to and from other departments, offices, and homes.

7. **Balancing**: 15-25%, see climbing.

8. **Stooping/Kneeling**: 10% of workday spent stooping/kneeling while retrieving supplies from bedside stands, bathrooms, storerooms, etc.

9. **Bending**: 20% of workday spent bending at the waist while performing patient assessments and treatments, gathering supplies, assisting with patient positioning, adjusting patient beds and exam table, bathing patients, and emptying drainage apparatus.

10. **Crouching/Crawling**: 2% retrieving patient belongings.

11. **Reaching/Stretching**: 35% of workday spent reaching/stretching administering and monitoring IV therapy, gathering supplies, operating the computer, disposing of equipment and linens, assisting with patient positioning, connecting equipment. Cleaning office equipment. Retrieving patient files.

12. **Manipulating**: 90% hand-wrist movement, hand-eye coordination, simple firm grasping required and 90% fine and gross finger dexterity required to calibrate and use equipment, perform CPR.

13. **Feeling**: 90% normal tactile feeling required to complete physical assessment including palpation and notation of skin temperature.

14. **Twisting**: 15% of workday spent twisting at the waist while gathering supplies and equipment, administering care, and operating equipment.

15. **Communicating in verbal and written forms**: 95 % ability to communicate nursing actions, interpret client responses, initiate health teaching, document and understand health care activities, and interact with clients, staff and faculty.

16. **Hearing**: 95% ability to hear and interpret many people and correctly interpret what is heard; auscultation, physicians orders whether verbal or over telephone, client reports and cries for help, fire and equipment alarms, etc.

17. **Seeing**: 95% acute visual skills necessary to detect signs and symptoms, coloring and body language of patients, color of wounds and drainage, and possible infections anywhere. Interpret written words accurately, read characters and identify colors in the client record and on the computer screen.

COLLEGE OF THE REDWOODS NURSING AND HEALTHCARE PATHWAYS
PHYSICAL EXAMINATION FORM

Student Name_____ Student Date of Birth_____ Student ID No. _____

Age_____ Weight_____ Height_____ Temp_____ Pulse_____ BP_____

Hearing: R_____/15 (Whisper Test) L_____/15

Vision: Uncorrected: R 20/_____ L 20/_____ Color Vision_____

Corrected: R 20/_____L 20/_____Test Used_____

Abnormal	Normal		Please note details of abnormalities
		Skin	
		Head	
		Eyes	
		Ears	
		Nose, Throat	
		Teeth, Mouth	
		Neck, Thyroid	
		Chest	
		Heart	
		Lungs	
		Abdomen	
		Hernia	
		Back	
		Extremities	
		Glandular	
		Speech	
		Neurological	

Name: _____

Date: _____

Recommendations:

1. Are any of the following contraindicated for this person?
   Bending □ Yes □ No Stooping □ Yes □ No Lifting □ Yes □ No
   Comments: _____
   _____
   _____

2. Rate this person's health as □ Good □ Average □ Frail
   State general impression of this person, including emotional stability, past and present (comments or correspondence regarding physical or emotional problems will be appreciated): _____
   _____
   _____

3. Can this person perform the clinical functions of the health occupations program as described in the attached Health Occupations Physical Requirement form? □ Yes □ No
   If not, explain need for accommodations if possible: _____
   _____
   _____

4. I recommend this person for participation in the clinical portion of the Health Occupations Programs: □ Yes □ No

5. This examinee is sufficiently free of disease to perform assigned duties and does not have any health conditions that would create a hazard for him/herself, fellow employees, patients or visitors: □ Yes □ No
   If not, explain: _____
   _____
   _____
   _____
   _____

Provider Signature – Please Complete

Date of Exam:	**MD, PA, FNP Name (Please Print):**
Examinee advised of abnormal findings? **□Yes □ No**	**Signature of MD, PA, FNP:** _____ **Address:** _____ **City, State:** _____

Required Immunizations and Vaccines for Nursing and Healthcare Pathways

To the student: Please bring all your immunization records to your physical exam appointment. **Proof of immunizations/vaccines will be uploaded into Complio as instructed in the program orientation.**

To the provider: Please confirm immunity, re-immunize, or obtain titers as needed.

The following immunizations are required before the semester begins:

1. **TB Skin Test**
   A negative 2-step skin test within the last 6 months (and then a one-step test annually), OR a negative QuantiFERON Gold blood test within the last 6 months and repeated annually. (Positive PPD = Chest X-ray - no older than one year - or symptom review., repeated every three years. If your X-ray is positive, you must submit proof of completing INH Prophylaxis within the last year.)

2. **TDaP** – within the last 10 years.

3. **Varicella (Chicken Pox)**
   Either two immunizations, OR positive Varicella titer (proof of immunity) within last 6 months. (Date of disease not acceptable.) If your titer result is 'Non-Immune' or 'Equivocal' you must provide proof of a booster for Varicella, followed by either a 2nd booster or an 'Immune' Antibody Titer for Varicella one month later.

4. **MMR (Measles, Mumps, Rubella)**
   Two doses of MMR, or measles vaccination on or after first birthday, OR positive MMR Titer (proof of immunity) within last 6 months. If Vaccinated Separately: Need proof of 2 Measles vaccinations, 1 Mumps vaccination and 1 Rubella vaccination.
   If Childhood Series Documentation is Unavailable: Get titers for the 3 diseases. If any titer is 'Non-Immune', or 'Equivocal' you must submit 2 Post Titer MMR Doses.

5. **Hepatitis B**
   Three-dose series, OR positive Hepatitis B Titer (proof of immunity) within last 6 months. If the titer comes back 'Non-Immune' or 'equivocal', you must restart a new 3-injection Hepatitis B vaccine series. The timeline for Hep B vaccinations is 1st injection + 1 Month until + 2nd injection+ 5 Months until + 3rd injection.

Required between Aug. 1 – 15:

1. Annual COVID vaccine/booster (or declination)

2. Annual Flu vaccine (or declination)

College of the Redwoods Nursing and Healthcare Pathways Health History Form

Name: _____ **Date:** _____

Have you ever had any of the following?

	Y	N		Y	N
1. Asthma or sinus disease?			11. Arthritis, bone or joint disorders?		
2. Heart disease/hypotension or hypertension?			12. Diabetes?		
3. Kidney disease?			13. Anxiety, depression, or mental health disorders?		
4. Convulsions or epilepsy?			14. Problems with alcohol or drug use?		
5. Lung condition?			15. Allergies to foods or medications?		
6. Hernia?			16. Have you ever hurt your back?		
7. Ulcers?			17. Have you any permanent conditions due to disease or injury?		
8. Fainting spells?			18. Are you now taking any medication on a regular basis?		
9. Head or neck injury?			19. Have you ever been confined in a hospital?		
10. Broken Bones?			20. Indicate date last treated by a physician:_____		

Details in connection with questions answered "Yes" above:

No.	Date	Name and address of physician and/or hospital	Give full details for each question answered "Yes"

To the student: I, _____, grant College of the Redwoods or its representative permission to release this health history and physical examination information to affiliated clinical placement agencies upon reasonable written request. Failure to grant permission makes me ineligible to participate in the program.

I certify that the above information is true and correct. Program: _____

_____ _____

Signature of Student Date

**** PLEASE SUBMIT ALL PAGES OF THIS FORM WITH THE FOLLOWING NAMING CONVENTION:**

Last name, form name, semester EX: Smith, Physical, F26