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Essential Function and Physical Assessment Form

CONFIDENTIAL

PART 1: ESSENTIAL FUNCTION ASSESSMENT – to be completed by the student

To participate in the nursing program and to promote safety and quality patient care, students must be able, with or without reasonable accommodation, to meet the essential emotional and physical requirements of the College’s Department of Nursing and the clinical partners with which the students will be placed. Satisfactory completion of clinical requirements is required to complete the nursing program. Students are required to travel to and perform clinical duties at facilities with unpredictable environments and patient needs. The nursing program is both physically and emotionally demanding, and students need to be able, with or without reasonable accommodation, to meet these demands. The following requirements are necessary for all nursing students to ensure their safety and the safety of and quality care for their patients. When applicable, students and faculty should work with Student Disability Services to determine what disability-related accommodations may be needed by a student and would be reasonable in a classroom and clinical setting to enable a student to participate and satisfy essential requirements.

Students - please note your ability to perform the following essential functions, with or without any potential need for accommodations based on any mental or physical condition:

|  |  |  |
| --- | --- | --- |
| **Essential Requirements** | **No Accommodation**  **Needs** | **Accommodation Needs** |
| **Emotional:** The student must have sufficient emotional stability to perform under stress produced by both academic study and the necessity of performing nursing care in real patient situations while being observed by the instructors and other health care personnel. |  |  |
| **Standing/Walking**: Standing and walking is required for the majority of time in an academic class, simulation setting, or spent in the clinical area (up to 4-8 hours at a time). Standing in one position is required while performing certain aspects of patient care. Walking occurs on vinyl, tile, linoleum, or carpeted floors. |  |  |
| **Sitting**: Sit while in class, doing academic work, or, for simulations or clinical settings, charting or entering data into a computer. One may also sit while receiving/giving verbal reports at the start/end of one's clinical shift. It is also possible that sitting may occur during breaks and meal periods. Total sitting is typically less than two hours for each eight-hour clinical shift, depending on clinical assignment. |  |  |
| **Lifting**: Regular lifting of medical supplies and equipment weighing up to 50 pounds is required. One is required to assist in lifting and transferring patients of varying weights and is expected to request assistance when lifting, ambulating, and repositioning patients. One must be able to support at least 75 pounds of human weight to reposition, transfer, and ambulate patients safely. |  |  |
| **Carrying**: Frequent carrying of medical supplies and equipment weighing up to 50 pounds is required. |  |  |
| **Pushing/Pulling**: Pushing/pulling 70-100 pounds is required when administering patient care, as well as when pushing equipment such as oxygen tanks and monitors, and when transporting patients in wheelchairs, beds, or gurneys. Pushing is required at 3.5 pounds of pressure when administering CPR. Full manual dexterity of both upper extremities is required. |  |  |
| **Climbing**: Limited climbing is needed, one may be required to climb a step stool. |  |  |
| **Bending**: Bending is required when administering patient care. One must be able to bend to touch the floor to remove environmental hazards. |  |  |
| **Reaching**: Reaching above one's head is required when performing aspects of care such as hanging and adjusting IV bags. |  |  |
| **Squatting/Kneeling**: Squatting or kneeling is required when operating medical equipment and performing aspects of patient care, such as CPR. |  |  |
| **Twisting**: Twisting at the waist is required when bathing patients and performing other procedures. |  |  |
| **Speaking**: Must be able to speak and understand the English language to effectively communicate, assess, and educate patients and families who are English speaking. One must also be able to communicate effectively orally and in writing with physicians, other nurses, and other professionals involved in patient care. |  |  |
| **Hearing**: One must be able, with or without reasonable accommodation, to effectively obtain information needed to and to communication information necessary to perform physical assessments, which may include listening with a stethoscope for bowel, heart, and lung sounds. One must also be able to detect subtle, yet critical information regarding patient conditions including alarms, and to communicate with physicians and other professionals involved in patient care. |  |  |
| **Visual Acuity**: Must have sufficient visual acuity, with or without reasonable accommodation, for monitoring equipment, reading medical data, preparing and administering medications and injections, and performing physical assessments of patients including subtle changes in color. |  |  |
| **Depth Perception**: Required for fine tasks such as administering injections, sterile catheter insertions (urinary, IV), and nasogastric tube insertions. |  |  |
| **Fine Motor Skills**: One must have sufficient fine hand motor skills, with or without reasonable accommodation, to be able to grasp and control medical equipment, and to perform precise procedures such as sterile dressing changes. Ability to grasp objects such as a pen to prepare any necessary handwritten reports is also required. |  |  |
| **Tactile Sensation**: Students must have sufficient tactile abilities be able to assess patients through palpation with fingers and hands and must be able to distinguish between warm/cold and be able to feel vibrations. |  |  |
| **Smell**: One must have sufficient ability to detect odors indicating unsafe conditions or changing patient status. |  |  |

Adapted from https://www.redlandscc.edu/academics/academic-departments/nursing/requirements

By signing below, I attest that I have reviewed the above information and am able, with or without reasonable accommodation to safely perform the above essential functions. If I need any reasonable accommodations due to a mental or physical condition to safely perform the above functions, I understand that it is my obligation to promptly contact the College’s Disability Services office to engage in an interactive process about my needs and for the College to determine if I can be granted reasonable accommodations without undue hardship. I also certify that the information provided by me herein is true and correct to the best of my knowledge. I am aware that this information will be released to clinical affiliations upon request and I consent to such disclosure. I agree to immediately communicate any changes in my ability to safely perform the above essential duties and any potential accommodation needs on my part to the College. I will communicate these changes to a nursing faculty member or advisor.

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PART 2: PHYSICAL EXAM – to be completed by the healthcare provider

Date of Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_ Temp: \_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_ Resp: \_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **WNL** | **Exam** | **Concerns** |
|  | HEENT |  |
|  | Neck |  |
|  | Skin |  |
|  | Respiratory |  |
|  | Cardiovascular |  |
|  | Gastrointestinal |  |
|  | Musculoskeletal |  |
|  | Neurological |  |

Does your examination of the student reveal any evidence of communicable disease? Yes No

If yes, please explain:

Assessment of Ability to Safely Meet Essential Requirements:

□ The student is found to be in good physical and mental health as outlined in the physical exam. I have reviewed the student’s self-assessment of their ability to complete the essential functions of a student nurse and determined that this student may safely participate in classroom and clinical experiences with no accommodations.

OR

□ Upon review of the results of the physical exam and/or essential function assessment, I recommend that accommodations be made for this student to safely participate in classroom and a clinical setting.

Diagnosis:

Requested accommodations:

Period during which accommodations are needed:

Provider Name (Physician or Advanced Practice Provider): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PART 3: IMMUNIZATION RECORD and TB TEST

|  |  |
| --- | --- |
| **Vaccine** | **Date(s) Received** |
| MMR | Dose 1: |
|  | Dose 2: |
| Tdap | Dose: |
|  | Booster (Td or Tdap required every 10 years): |
| Varicella | Dose 1: |
|  | Dose 2: |
|  | Titer draw date (if had chicken pox and no vax): |
| Hepatitis B | Dose 1: |
|  | Dose 2: |
|  | Dose 3 (Engerix-B or Recombivax HB): |
| Influenza | Most recent annual dose: |
| COVID-19 | Dose 1 Date and Manufacturer: |
|  | Dose 2 Date and Manufacturer: |
|  | Booster: |
|  | Booster: |
|  | *If exemption is desired, schedule meeting with Nursing Department Chair to learn about the process.* |

|  |  |  |
| --- | --- | --- |
| **Patient Questionnaire Regarding TB** | **Yes** | **No** |
| Temporary or permanent residence of ≥1 month in a country with a high TB rate  (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe) |  |  |
| Current or planned immunosuppression  (Including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist [e.g., infliximab, etanercept, or other], chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication) |  |  |
| Close contact with someone who has had infectious TB disease since the last TB test |  |  |
| A bad cough that lasted 3 weeks or longer |  |  |
| Pain in the chest |  |  |
| Coughing up blood or sputum |  |  |
| Weakness or fatigue |  |  |
| Weight loss |  |  |
| No appetite |  |  |
| Chills |  |  |
| Fever |  |  |
| Sweating at night |  |  |

Proof of negative Tuberculosis (TB) test using ONE of the following methods:

|  |  |
| --- | --- |
| **Tuberculosis Test** | **Verification** |
| *Single-step Mantoux (TB skin test)*  Name of person administering test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Signature of person administering test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Location of test: R forearm L forearm Alternate site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_    Tuberculin manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name of reader:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of reader:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date and time read:  \_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_  Mm of induration:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Interpretation of reading:  Positive Negative |
| *QuantiFERON-TB Gold or T-SPOT (TB blood test)* | Date of blood draw:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***Stop here if TB test result is negative.***

**If student has a positive TB skin or blood test result, provider is to complete the following information:**

Date of normal chest x-ray: (must be within the past 5 years) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the student receive the TB vaccine (BCG)? Yes No If yes, date received: \_\_\_\_\_\_\_\_\_\_

Provider Name (Physician or Advanced Practice Provider): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_