Rio Grande Valley College

Nursing Program Entrance Requirements

Steps (1-2) **MUST** be completed as noted below.

1) We utilize an Immunizations Compliance Program called COMPLIO by AMERICAN DATABANK. **During acceptance meeting** you will create your profile. Funds need to be available on debit/credit card $67.00 *(DAY)*/ $84.00 *(EVENING/WEEKEND)*.
2) A complete Drug Screen will be required by the first day of class. This will be discussed during the acceptance meeting.

Steps (3-6) **MUST** be completed by the date provided at orientation. Failure to do so may result in removal from the program.

3) Current American Heart Association CPR Certification Submit to Complio
4) Driver License (Original, no photocopies or temporary paper receipt) Submit to Complio (as well)
5) Physical Exam Form (completed on both sides) Submit to Complio
6) Required Immunization Documents Submit to Complio
   Acceptable documents: Original Immunization Card with validations, Immtrac form from County (signed/ stamped), high school immunization history (signed/stamped), documentation from physician's office on letterhead (signed/ stamped) no flow sheets.
   a) Current Tuberculin Skin Test
      i) If Tb Skin Test is negative - reading must be in millimeters, mm
      ii) If Tb Skin Test is positive, history of positive, or received out of the country vaccine - provide proof and wait for direction. **Do Not** get a Chest X-Ray (CXR) until Complio Team advises you to do so. CXR result will need to be achieved with negative results for disease.
   b) Tdap (must be the combination of Tetanus, Diphtheria and Pertussis) - Must be completed every 10 years.
   c) Hepatitis B Series (three) or Hepatitis B titer indicating antibodies present.
   d) Varicella Series (two) or titer showing antibodies present (if history).
   e) MMR Series (two) (Measles, Mumps and Rubella) vaccine or titer showing antibodies present.
   f) Flu Vaccine (October 1st – April 30th)
   g) Meningococcal Vaccine (required for students who are 22 years of age or younger by the first day of class.)
   h) COVID vaccine (1 dose J&J or 2 dose Moderna/Pfizer/Astra Zeneca)
7) Fingerprints for Criminal Background Check
   (Complete Only When Authorized By TBON approximately 1 month into the program).

For any questions regarding Complio or verification of immunizations please contact Complio Team at complioteam@rgvcollege.edu.

Notes: _____

Rio Grande Valley College

5419 N. Cage Blvd.
Pharr TX 78577
(956) 781-6800 PH. (956) 781-6807 Fax
www.rgvcollege.edu

PHYSICAL EXAM CERTIFICATION

Please fill out top portion before the physician examination

Name _____ D.O.B._____

Address_____City_____Zip Code_____

Phone_____ Age_____

Emergency contact person:_____Phone #:_____Relationship:_____

Does student have insurance?_____Yes _____ No

Name of insurance provider: _____

** Required to be completed*

To be completed by a U.S. Physician, PA, NP:

*** Past Medical History/Illnesses: (Please check those that apply)**

( ) Measles	( ) Scarlet Fever	( ) Heart Disease
( ) Whooping Cough	( ) Diphtheria	( ) Chorea (St. Virus Dance)
( ) Polio	( ) Chicken Pox	( ) Epilepsy
( ) Rheumatic Fever	( ) Diabetes	( ) Frequent colds #/year _____
( ) Hay fever or Asthma		

List any other serious illness, operation, or injury, and date when it occurred. _____

_____

_____

***Please list any known allergies and reaction:**_____

***Physician Examination:**

Height _____Weight_____Temperature_____B/P_____

Eyes: Vision R_____L____ or with Glasses R _____L_____ Ears: R____L_____ Hearing R_____L_____

Nose _____Sinuses_____

Teeth _____Tonsils_____

Thyroid _____Skin_____

Heart _____Lungs_____

Abdomen _____ Hernia_____

Feet: R _____L_____ Varicose Veins_____

Posture _____Spinal Curvature_____Reflexes_____

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Physical Exam Certification (cont'd)

REMARKS AND RECOMMENDATIONS

*Defects found: _____

_____

_____

*Recommendations: _____

_____

_____

*In your opinion, is the individual in a suitable physical and emotional condition to enroll in a NURSING EDUCATION program?

_____ Yes

_____ No; if not, please comment:_____

_____

_____ _____

Signature of Examining Physician,PA,NP Date

Please place office stamp in box below with clinic name, address & phone number.