

Union County College – Practical Nursing Program

Student Health Form - SAMPLE

NOTE: All areas must be completed

Name: Student Nurse SS # 000-00-0000

Address: 1000 Hard Work Lane
Professional City, NJ 07777

Phone: Home - 555-123-3456 Cell – 555-333-5577
Work - _____

Date of Birth: 12/25/75 Sex: Male Female _____

Personal Health Overview (completed by student):

Identify any current health problems: None known

Prior illnesses/hospitalizations/surgeries: Hernia repair (1994)

Known allergies: None

Medications taken: None

Physical Examination (completed by Licensed Physician or Nurse Practitioner):

Height: 6 feet Weight: 190 lbs

Pulse: 76 Blood Pressure: 120/80

Vision: Right 20/20 Left 20/20

Hearing: Right 100% Left 100%

	Within Normal Limits	Abnormal Findings	Description of Abnormal Findings & Treatment Received
General appearance	X		
Skin	X		
Eyes	X		
Ears	X		
Nose	X		
Neck/Throat	X		
Chest/ Respiratory Breasts Cardiac	X		
Abdomen Gastrointestinal	X		
Urinary	X		
Genital – Reproductive	X		
Extremities Vascular	X		
Musculoskeletal	X		
Endocrine	X		
Neurological	X		
Mental Status	X		

Any limitations in physical activity? No X Yes _____

If yes, please explain: _____

The student is able to participate in clinical patient care activities without restrictions:

Yes X No _____

If no, please explain the specific restrictions: _____

The student is free of contagious diseases: Yes X No _____

If no, please explain: _____

Proof of health insurance coverage (attach copy)

Any other specific information, such as activity restrictions, should be attached.

Laboratory: (copies of test results may be attached)

CBC: Date: 11/1/07 Within Normal Limits: Yes X No _____

Urinalysis: Date: 11/1/07 Within Normal Limits: Yes X No _____

Blood Chemistry/Metabolic Panel: Date: 11/1/07

Within Normal Limits: Yes X No _____

Immunizations:

Blood titer levels need to be completed! Receipt of vaccine or history of the disease does not demonstrate immunity status. After any vaccines are received, a follow-up blood titer is required to determine immunity. **Actual blood titer values and immunity status for each are required to be written in by the health care provider.**

	Blood Titer Level	Immunity Status	Vaccines – Dates Received	Follow-Up Titers & Immunity
Measles	2.7	Immune		
Mumps	4.3	Immune		
Rubella	6.8	Immune		
Varicella	0.1	Non-Immune	11/6/07	3.2 - Immune
Hepatitis B	Negative antibodies	Non-immune	1 st dose: 11/6/07 2 nd dose: 3 rd dose:	

Hepatitis C: Date tested 11/1/06 Presence of infection Yes _____ No X

Flu Vaccine: Date Received _____ Declination of flu vaccine SN 11/1/07

Tetanus, Diphtheria, Pertussis Vaccine (Tdap)*: Date received 11/6/07

*Receipt of vaccine must be within 2 years of the date on this form

Declination of Tdap vaccine _____

Urine Drug Screening with confirmation: Date: 11/1/07 Negative X Positive _____

NOTE: If vaccines are declined, signed copies must accompany this form. Students who are not immune to the infectious diseases noted may be prohibited by the clinical agencies from participating in clinical experiences in areas where disease transmission poses a high risk to patients, staff, visitors, and/or students.

