

**Union County College – Practical Nursing Program**

**Student Health Form**

**NOTE: All areas must be completed**

Name: \_\_\_\_\_ SS # \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: Home - \_\_\_\_\_ Cell - \_\_\_\_\_  
Work - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

**Personal Health Overview (completed by student):**

Identify any current health problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prior illnesses/hospitalizations/surgeries: \_\_\_\_\_

\_\_\_\_\_

Known allergies: \_\_\_\_\_

Medications taken: \_\_\_\_\_

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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Vision: Right \_\_\_\_\_ Left \_\_\_\_\_

Hearing: Right \_\_\_\_\_ Left \_\_\_\_\_

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

Any limitations in physical activity? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please explain the specific restrictions: \_\_\_\_\_

\_\_\_\_\_

The student is free of contagious diseases: Yes \_\_\_\_\_ 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 as additional reference)**

CBC: Date: \_\_\_\_\_ Within Normal Limits: Yes \_\_\_\_\_ No \_\_\_\_\_

Urinalysis: Date: \_\_\_\_\_ Within Normal Limits: Yes \_\_\_\_\_ No \_\_\_\_\_

Blood Chemistry/Metabolic Panel: Date: \_\_\_\_\_

Within Normal Limits: Yes \_\_\_\_\_ 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.**

	<b>Blood Titer Level</b>	<b>Immunity Status</b>	<b>Vaccines – Dates Received</b>	<b>Follow-Up Titers &amp; Immunity</b>
Measles				
Mumps				
Rubella				
Varicella				
Hepatitis B			1 <sup>st</sup> dose: 2 <sup>nd</sup> dose: 3 <sup>rd</sup> dose:	

Hepatitis C: Date tested \_\_\_\_\_ Presence of infection Yes \_\_\_\_\_ No \_\_\_\_\_

Flu Vaccine: Date Received \_\_\_\_\_ Declination of flu vaccine \_\_\_\_\_

Tetanus, Diphtheria, Pertussis Vaccine (Tdap)\*: Date received \_\_\_\_\_

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

Declination of Tdap vaccine \_\_\_\_\_

Urine Drug Screening with confirmation: Date: \_\_\_\_\_ Negative \_\_\_\_\_ 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.**

**Two-Step Mantoux Test:\*\***

Date: \_\_\_\_\_ Negative \_\_\_\_\_ Positive \_\_\_\_\_

Chest X-Ray: Date: \_\_\_\_\_ Results: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

\*\* A two-step Mantoux test is not required if documentation is provided of a negative Mantoux within 12 months of the date noted by the healthcare provider. Students who have positive Mantoux tests or who are not able to take the Mantoux (prior receipt of BCG) are required to have chest x-rays or pulmonary clearance from the provider.

***Mantoux testing, chest x-ray, or pulmonary clearance is required on an annual basis.***

\_\_\_\_\_  
Examiner's Name, Credentials, License #, Address (official stamp)

\_\_\_\_\_  
Examiner's Signature

\_\_\_\_\_  
Date