Butler Community College

Entry Level
Department of Nursing
HEALTH RECORD

DIRECTIONS: Have your primary health care provider fill out and sign the Health Record and Certification of Immunizations. Both must be submitted College Health as specified in the course syllabus. The physical must be completed **no sooner** than 3 months before the first day of class.

Name _____ Birth Date _____
Last First Middle

I. **MEDICAL EXAMINATION**

Physician check if any abnormal history or physical findings

_____ Cardiovascular System Remarks _____
_____ Respiratory Remarks _____
_____ Gastrointestinal Remarks _____
_____ Genitourinary-Gynecologic Remarks _____
_____ Central Nervous System Remarks _____
_____ Musculo-Skeletal Remarks _____
_____ EENT (include visual & hearing acuity) Remarks _____
_____ Scoliosis Remarks _____

List all medications student is taking: _____
_____

Are there any health conditions which should be called to our attention (including communicable or infectious disease or latex allergies)? _____

The clinical experience for nursing students may require prolonged standing and walking; frequent heavy lifting, pushing, pulling, carrying; occasional climbing, stooping, balancing, kneeling; constant need for good vision and hearing; ability to tolerate stressful situations; and occasional exposure to hazardous material.

List any contra-indications to participation in clinical nursing experiences, taking in consideration the above requirements, and any condition the student may have that would pose a safety concern to clients, faculty, students, clinical staff of the facility or to the student themselves_____

This is to certify that I have examined this student and find that he/she is able to participate in ANY clinical nursing experiences.

Date of examination _____ Examining Physician/NP/PA _____
Address _____
_____

II. REQUIRED IMMUNIZATIONS MUST BE ON FILE IN COLLEGE HEALTH
Immunizations on the reverse side of this form must be documented by a physician, their office person, or a health department representative. Students are not authorized to complete the form

III. TUBERCULIN SKIN TEST/BLOOD TEST REQUIRED ANNUALLY. SEE BACK OF THIS FORM
A chest x-ray (14"x17") is required for positive reactors to the TSPOT/Quantiferon test. If positive reactor with chest x-ray on file, student must document absence of symptoms and awareness of need to report occurrence of TB symptoms to Butler College Health Service (316) 322-3371 should they develop. If the student has a positive QFT/TSPOT and an abnormal Chest X-ray and/or symptom of active TB (cough lasting> 3 weeks, fatigue, night sweats, weight loss, anorexia, etc.) three sputum's MUST be negative before the student will be allowed to attend class and treatment will be mandatory.

IV. CPR CARD AND MEDICAL INSURANCE CARD MUST BE ON FILE IN COLLEGE HEALTH

College Health Fax: (316) 323-6850 Email: collegehealth@butlercc.edu

(Over)

Revised 2022

BUTLER COMMUNITY COLLEGE
ENTRY LEVEL
HEALTH RECORD

Student Name: _____ Birth Date: _____

Required immunizations, Tests, & or Titers (Attach a Photocopy)
(to be completed by the Health Department or Physician, NOT the student)

1. **TDAP** in the last 10 years — **Date:** _____

2. **MMR**
   (2 shots needed at least 30 days apart)
   (Cannot be given during pregnancy)
   #1 Date: _____
   #2 Date: _____
   OR Measles, Mumps, and Rubella Titer — Date: _____ Results: _____

3. **VARICELLA**
   (2 shots needed at least 30 days apart)
   (Cannot be given during pregnancy)
   #1 Date: _____
   #2 Date: _____
   OR Varicella Disease_____ (Date of disease) _____ (Physician Signature)
   OR Varicella Titer — Date: _____ Results: _____

4. **COVID-19**
   #1 Date: _____
   #2 Date: _____

5. **2-STEP TB SKIN TEST**
   (Plant dates must be at least 1 week apart)
   Date planted: _____ **Results:** _____ **mm** **Date read:** _____ **Read by:** _____
   Date planted: _____ **Results:** _____ **mm** **Date read:** _____ **Read by:** _____
   OR T-SPOT/QFT Test — Date: _____ Results: _____

6. **INFLUENZA** (Sept.1-Apr.30) — **Date:** _____

7. **HEPATITIS B**
   #1 Date: _____
   #2 Date: _____
   #3 Date: _____
   OR Signed Hepatitis A & B Waiver

The Hepatitis Vaccine is safe. You are considered to be a higher risk of contracting Hepatitis A & B because you will be working in the Pre-Hospital and Hospital setting. Approximately 15-20% of people who work in these areas are immune. If you are immune, you will of course not need immunized.

I understand the risks and benefits of immunization with the Hepatitis A & B vaccine.
Despite potential benefits, I prefer NOT to be immunized at this time.

Student Signature: _____ **Date:** _____

DOCUMENTATION
I certify I reviewed this student's vaccination record and transcribed it accurately.
The record presented: ❑ Kansas Immunization Record (pink card) ❑ Other Immunization record (Specify ____)

Staff Signature_____ **Date**_____ **Name of Agency** _____

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