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

Home Address _____

_____Phone No. _____

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 also 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 REQUIRED ANNUALLY. SEE BACK OF THIS FORM

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

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(over)

VACCINE	RECORD THE DATE EACH DOSE OF VACCINE WAS RECEIVED (to be completed by the Health Department or Physician, not the student)						
	1st	2nd	3rd	4th	5th	6th	7th
Tdap, DTP, DTaP and dT/Td **Must show booster within last ten (10) years. Tdap must be given if 2 or more years since last booster.** ***CIRCLE TYPE***	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -
MMR *(Measles, Mumps, and Rubella combined)* **Proof of two (2) required.** (If born before 1957 only 1 required)	- -	- -	Give TB skin test **first**; then MMR and/or Varicella. MMR & Varicella MUST be given after the 2-step skin test. Otherwise the skin test results may be invalid and will need to be repeated. There is a 30-day waiting period if MMR or Varicella is given prior to the TB skin test. If MMR and Varicella are both needed, give on the same day or there is a 30-day waiting period between each injection.				
Single Antigen Dose Only — **MEASLES** (Rubella/red measles/ 10-day measles)	- -	- -					
RUBELLA (German Measles/3-day measles)	- -	- -					
MUMPS							
Varicella *(Chickenpox)* **(If no vaccination, give date of disease _____ or submit titer).**	- -	- -					
HBV (Hepatitis B Vaccine) Recommended for **health care workers.** ***CIRCLE TYPE (HepA/B or Hep B)***	Hep A/B, Hep B - -	Hep A/B, Hep B - -	Hep A/B, Hep B - -				
Pneumonia Immunization (Encouraged if history of pneumonia, asthma, or lung disease).	- -						
Flu Vaccine (required during flu season).	- -	- -	- -	- -	- -	- -	- -
HAV (Hepatitis A Vaccine) *Optional*	- -	- -	- -				
Meningococcal Vaccine *Recommended but Optional*	- -						

DOCUMENTATION

I certify I reviewed this student's vaccination record and transcribed it accurately.

Signature_____ Date___-____-____

Name of Agency _____

The record presented was:

- ☐ Kansas Immunization Record (pink card).
- ☐ Other Immunization record (Specify_____).
- ☐ School Record.

A 2-step (1-3 weeks apart) PPD Tuberculin Test must be completed within the last three months. Only intradermal skin tests are accepted. A chest x-ray (14"x17") is required for positive reactors to the tuberculin test.
Report_____ Date_____.
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 (322-3371) should they develop*. A negative Quantiferon (QFT) annually is also accepted as proof of negative TB.

Two Step Tuberculin Skin Test	Date Given	Given By	Date Read	Read By	mm indur **Required**	
← **Intradermal PPD ONLY**					_____ **mm**	☐ Significant ☐ Non-Significant
↑ **Intradermal PPD ONLY** (1-3 weeks after above date)					_____ **mm**	☐ Significant ☐ Non-Significant

*If the student has a positive PPD or QFT and an abnormal Chest X-ray and/or symptoms of active TB (cough lasting> 3 weeks, fatigue, night sweats, weight loss, anorexia, ect.) three sputum MUST be negative before the student will be allowed to attend class and treatment will be mandatory.

Office Use Only: CPR Renewal Date: _____