



Annual Department of Nursing HEALTH RECORD

DIRECTIONS: Have your physician 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.

Any health condition that the student may have that would pose a safety concern to clients, faculty, employees or to the student themselves will not be allowed to participate in the clinical setting

List any contra-indications to participation in clinical nursing experiences. \_\_\_\_\_

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 \_\_\_\_\_

Address \_\_\_\_\_

II. REQUIRED IMMUNIZATIONS MUST BE ON FILE IN COLLEGE HEALTH.

III. TUBERCULIN SKIN TEST REQUIRED ANNUALLY. SEE BACK OF THIS FORM

# VACCINE

## RECORD THE DATE EACH DOSE OF VACCINE WAS RECEIVED (to be completed by the Health Department or Physician, not the student)

	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>	7 <sup>th</sup>
	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.
Tdap, DTP, DTaP and dT/Td <b>Must show booster within last ten (10) years. Tdap must be given if 2 or more years since last booster. <u>CIRCLE TYPE</u></b>	- - -	- - -	- - -	- - -	- - -	- - -	- - -
MMR ( <i>Measles, Mumps, and Rubella combined</i> ) <b>Proof of two (2) required.</b> (If born before 1957 only 1 required)	- - -	- - -	- - -	- - -	- - -	- - -	- - -
<b>Single Antigen Dose Only</b> MEASLES (Rubella/red measles/ 10-day measles) RUBELLA (German Measles/3-day measles) MUMPS	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Varicella ( <i>Chickenpox</i> ) (If no vaccination, give date of disease _____ or submit titer).	- - -	- - -	- - -	- - -	- - -	- - -	- - -
HBV (Hepatitis B Vaccine) Recommended for health care workers. <u>CIRCLE TYPE (HepA/B or Hep B)</u>	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) <i>Optional</i>	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Meningococcal Vaccine <i>Recommended but Optional</i>	- - -	- - -	- - -	- - -	- - -	- - -	- - -
I certify I reviewed this student's vaccination record and transcribed it accurately.	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.						
Signature _____ Date _____	Two Step Tuberculin Skin Test ← Intradermal PPD ONLY						
Name of Agency _____	Date Read By _____ Date Given By _____ mm indur Requi red						
The record presented was: <input type="checkbox"/> Kansas Immunization Record (pink card). <input type="checkbox"/> Other Immunization record (Specify _____). <input type="checkbox"/> School Record.	mm mm mm mm						
	<input type="checkbox"/> Significant <input type="checkbox"/> Non-Significant <input type="checkbox"/> Significant <input type="checkbox"/> 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: \_\_\_\_\_