## St. Joseph's College Department of Nursing STUDENT HEALTH FORM

Name				Gender	Date of Bi	rth/
(Last Name	e)	(First)	(Middle I)			
Address						
(St	reet)		(City)		(State)	(Zip Code)
Home Tel#		Ce	ell #		Email	
In case of emergen	cy, notify		Rel	ation	Cell#_	
***Health	Insurance	e plan: Attac	h copy (front & back	) of student's in	nsurance card	for our file***
Insurance Company	/ Name		Po	olicy #		
Group #		_Policy Holde	er:	Relatio	nship:	
		If Insuran	ce plan changes, please	e notify Nursing (	Office	
Г <u>.</u>						
Allergies:		List All Curre	ent Prescribed and O	ver the Counte	r Medications:	
			Review of S	vstems		
	1	T	T			
System	Negative	Positive	Comment on ALL P	ositive Respon	ses	
Neuro						
Cardio-Vascular						
Respiratory						
GI						
GU						
Ortho						
Endocrine						
Hemo						
Psych						
List any illness or cor	ndition, not	listed above,	for which you are now	being treated o	r were hospitali	zed for including the dates:

REQUIRED ON INITIAL PHYSICAL ONLY: TITRES NEED TO BE DONE ONE TIME ONLY  LAB REPORTS MUST BE ATTACHED FOR EACH TITRE!  Rubella Titre Value Result:  Result:  Varicella Titre Value Result:  Hepatitis B Value Result:  Hepatitis B Value Result:  Hepatitis B Vaccine: #1 Date: #2 Date: #3 Date:  Hepatitis C [Brooklyn ONLY] Value Result:  Hepatitis C [Brooklyn ONLY] Value Result:  NEGATIVE TITRES FOR RUBELLA, RUBEOLA AND MUMPS REQUIRE PROOF OF TWO (2) MMR's, A NEGATIVE VARICELLA TITRE REQUIRES PROOF OF TWO (2) VARICELLA VACCINES.  MMR #1: MMR #2:		חרטויים	CD ON INITIAL DI	IVCICAL CALLY, TIT	DEC NEED T	O DE DONE ONE T	TRAT ONLY
Rubella Titre Value		REQUIR	RED ON INITIAL PH	IYSICAL ONLY: III	KE2 NEED 10	O RE DONE ONE I	IIVIE ONLY
Rubeola Titre Value Result:			LAB REPO	ORTS MUST BE ATTA	ACHED FOR EA	ACH TITRE!	
Result:							
Waricella Titre Value Result:	,	Rubella Titre	Value		Result:		<del></del>
Mumps Titre Value Result:		Rubeola Titre	Value		Result:		<del></del>
Hepatitis B Value		Varicella Titre	Value		Result:		
#2 Date: #3 Date: #3 Date: #3 Date: #3 Date: #3 Date: #3 Date: #4		Mumps Titre	Value		Result:		
#2 Date: #3 Date: #4		Hepatitis B	Value		Result:		
IEGATIVE TITRES FOR RUBELLA, RUBEOLA AND MUMPS REQUIRE PROOF OF TWO (2) MMR's, A NEGATIVE VARICELLA TITRE REQUIRES PROOF OF TWO (2) VARICELLA VACCINES.  MMR #1:		•	#1 Date:	#2 Date:		#3 Date:	<del></del>
IEGATIVE TITRES FOR RUBELLA, RUBEOLA AND MUMPS REQUIRE PROOF OF TWO (2) MMR's, A NEGATIVE VARICELLA TITRE REQUIRES PROOF OF TWO (2) VARICELLA VACCINES.  MMR #1:					<b>.</b>		
MMR #1:	)	Hepatitis C [Bro	okiyn ONLY] value_		Result:		
Diptheria/TetanusPertussis: [Within Last 10 Years] (Tdap)Date:  If, as an adult you haven't had a vaccine that contains pertussis (whooping cough) the dose you receive needs to have pertussis in it.  Tuberculin Test  TB blood test (the QuantiFERON®-TB Gold in –Tube test (QFT-GIT) or the T-SPOT®TB test (T-Spot) Date Result  (PPD intradermal only) [MUST BE READ 48 – 72 HOURS LATER]  Date Implanted: Read: Date: by Result  INITIAL POSITIVE FINDINGS OF ALL TUBERCULOSIS TESTS REQUIRE A NEGATIVE CHEST XRAY REPORT. XRAY REPORT MILATTACHED: Date: Result:  NURSING STUDENTS ARE TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TO THE BEGINNING OF CLINICAL PRACTOR MUST SIGN A DECLINATION STATEMENT.  DECLINATION STATEMENT: I understand that due to my occupational exposure to blood or other potentially	11	ИR #1:		MMI	R #2:		
If, as an adult you haven't had a vaccine that contains pertussis (whooping cough) the dose you receive needs to have pertussis in it.  Tuberculin Test  TB blood test (the QuantiFERON®-TB Gold in —Tube test (QFT-GIT) or the T-SPOT®TB test (T-Spot) Date Result  (PPD intradermal only) [MUST BE READ 48 — 72 HOURS LATER]  Date Implanted: Read: Date: by Result  INITIAL POSITIVE FINDINGS OF ALL TUBERCULOSIS TESTS REQUIRE A NEGATIVE CHEST XRAY REPORT. XRAY REPORT MIL ATTACHED: Date: Result:  NURSING STUDENTS ARE TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TO THE BEGINNING OF CLINICAL PRACTOR MUST SIGN A DECLINATION STATEMENT.  DECLINATION STATEMENT: I understand that due to my occupational exposure to blood or other potentially	Ά	RICELLA #1:		VARI	CELLA #2:		
Date Implanted:					-4		
Date Implanted:Read: Date:byResult  INITIAL POSITIVE FINDINGS OF ALL TUBERCULOSIS TESTS REQUIRE A NEGATIVE CHEST XRAY REPORT. XRAY REPORT MURATTACHED: Date: Result:  NURSING STUDENTS ARE TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TO THE BEGINNING OF CLINICAL PRACTOR MUST SIGN A DECLINATION STATEMENT.  DECLINATION STATEMENT: I understand that due to my occupational exposure to blood or other potentially.	If p	, as an adult you ha ertussis in it. uberculin Test	ven't had a vaccine th	nat contains pertussis	(whooping cou	ugh) the dose you red	
ATTACHED: Date: Result: R	If p T T	as an adult you ha ertussis in it. uberculin Test B blood test (the Qu	ven't had a vaccine th	nat contains pertussis in –Tube test (QFT-G	(whooping cou	ugh) the dose you red	
OR MUST SIGN A DECLINATION STATEMENT.  DECLINATION STATEMENT: I understand that due to my occupational exposure to blood or other potentially	If p T T (	, as an adult you ha ertussis in it. uberculin Test B blood test (the Qu PPD intradermal on	ven't had a vaccine th uantiFERON®-TB Gold ly) [MUST BE READ 48	in –Tube test (QFT-G	(whooping cou	ugh) the dose you red	Date Result
<b>DECLINATION STATEMENT:</b> I understand that due to my occupational exposure to blood or other potentially	TT (	, as an adult you ha ertussis in it. uberculin Test B blood test (the Qu PPD intradermal on Pate Implanted:	ven't had a vaccine the same t	in –Tube test (QFT-G B – 72 HOURS LATER) by	(whooping cou	ugh) the dose you red  OT®TB test (T-Spot) C  Result  E CHEST XRAY REPOR	Pate Result T. XRAY REPORT MUS
	If p T T (II A N	, as an adult you ha ertussis in it.  uberculin Test B blood test (the Qu PPD intradermal on Date Implanted:  UITIAL POSITIVE FIN TTACHED: Date:  URSING STUDENTS	ven't had a vaccine the same t	in –Tube test (QFT-G B – 72 HOURS LATER) by CULOSIS TESTS REQUI Result	(whooping cou	ugh) the dose you red  OT®TB test (T-Spot) C  Result  E CHEST XRAY REPOR	Pate Result  ET. XRAY REPORT MUS
infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed of the	If p T T (II A NO	as an adult you ha ertussis in it.  uberculin Test B blood test (the Quant of the December of	ven't had a vaccine the same t	in –Tube test (QFT-G B – 72 HOURS LATER] by  CULOSIS TESTS REQUI Result ED WITH HEPATITIS B	(whooping cou	OT®TB test (T-Spot) C  Result  CHEST XRAY REPOR	Pate Result T. XRAY REPORT MUS G OF CLINICAL PRACTIO
to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B vaccination at this time. I understand		as an adult you hat ertussis in it.  uberculin Test B blood test (the Quarter Implanted:  UITIAL POSITIVE FIN TTACHED: Date:  URSING STUDENTS R MUST SIGN A DECECTION STA	ven't had a vaccine the same in the same i	in –Tube test (QFT-GIB – 72 HOURS LATER)by CULOSIS TESTS REQUIRED WITH HEPATITIS BIT. tand that due to my acquiring Hepatitis	(whooping country) or the T-SPC  RE A NEGATIVE  VACCINE PRIO  occupational B virus (HBV)	Result  E CHEST XRAY REPORT  OR TO THE BEGINNING  exposure to blood infection. I have be	OateResult  ST. XRAY REPORT MU  G OF CLINICAL PRACTI or other potentially ten informed of the

by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Date: \_\_\_\_\_ SIGNATURE: \_\_\_\_

IMPORTANT INFORMATION - PLEASE READ AND COMPLETE Statement by Student: I have personally supplied the above Health History information and attest that it is true and complete to the best of my knowledge. I understand that this information is strictly confidential and will not be released to anyone without my written consent. I attest to the fact that I am free of habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances. SIGNATURE: PHYSICAL FORM This form must be completed and signed by a Licensed HEALTH CARE PROVIDER (physician, nurse practitioner, or physician's assistant), NOT a family member. I certify that \_ is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risk to patients or other personnel or which may interfere with the performance of his or her duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter individual behavior or thought processes. This individual is able to participate in clinical learning experiences as a student in the Nursing Program without restrictions. B.P.\_\_\_\_\_ Pulse\_\_\_\_ Respirations\_\_\_\_\_ Vision\_\_\_\_ Hearing\_\_\_\_ Allergy to Latex: Yes: \_\_\_\_ No: \_\_\_\_ Other Allergies: \_\_\_\_\_ Illnesses: Restrictions on Activity: Medications: \*\*Students with disabilities are considered on an individual basis. Students must be able to meet program objectives. Is this student currently under any form of medical, emotional or psychiatric treatment? (Explain) Name of Health Care Provider: \_\_\_\_\_\_ **STAMP REQUIRED** Address: \_\_\_\_\_ **HEALTH CARE PROVIDER SIGNATURE:** 

Date: