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

Name_____ **Gender**____ **Date of Birth**___/___/___
(Last Name) (First) (Middle I)

Address_____
(Street) (City) (State) (Zip Code)

Home Tel# _____**Cell #**_____**Email**_____

In case of emergency, notify_____**Relation**_____**Cell#**_____

*****Health Insurance plan: Attach copy (front & back) of student's insurance card for our file*****

Insurance Company Name _____Policy #_____

Group #_____Policy Holder: _____ Relationship: _____

If Insurance plan changes, please notify Nursing Office

Allergies:	**List All Current Prescribed and Over the Counter Medications:**

Review of Systems

System	Negative	Positive	Comment on ALL Positive Responses
Neuro			
Cardio-Vascular			
Respiratory			
GI			
GU			
Ortho			
Endocrine			
Hemo			
Psych			

List any illness or condition, not listed above, for which you are now being treated or were hospitalized for including the dates:

_____

_____

Please explain if you are you being treated or have you been treated for Substance Abuse (Alcohol/Drugs): _____

_____

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: _____**
- **Rubeola Titre Value _____ Result: _____**
- **Varicella Titre Value _____ Result: _____**
- **Mumps Titre Value _____ Result: _____**
- **Hepatitis B Value _____ Result: _____**

Hepatitis B Vaccine: #1 Date: _____ #2 Date: _____ #3 Date: _____

- **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:** _____

VARICELLA #1: _____ **VARICELLA #2**: _____

- **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 MUST BE ATTACHED: Date: _____ Result: _____

- **NURSING STUDENTS ARE TO BE IMMUNIZED WITH HEPATITIS B VACCINE PRIOR TO THE BEGINNING OF CLINICAL PRACTICE OR MUST SIGN A DECLINATION STATEMENT.**
- **DECLINATION STATEMENT:** I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed of the need to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B vaccination at this time. I understand that 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.

Date: _____ 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: _____

Injuries: _____

Restrictions on Activity: _____

Medications: _____

Disabilities: _____

****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: _____

Phone: _____

HEALTH CARE PROVIDER SIGNATURE:

_____ Date: _____