Revised 9/2019

**Radford University School of Nursing**

# HEALTH RECORD FORM

The School of Nursing requires a complete Health Record and Certificate of Immunization be completed and signed by a licensed health care provider. All areas must be completed, if they do not apply, mark N/A. Your offer of admission can be denied if the health record is such that you would not be successful in meeting the objectives of the School of Nursing. The School of Nursing requires you to do a complete health record before you start the nursing major. If the health record shows issues of concern the results will be shared with the clinical agencies that the School of Nursing uses for clinical. The clinical agencies will determine whether you can come to their agency for clinical. If the clinical agency refuses to allow you in clinical you will be dismissed by the School of Nursing.

Fall admission due date is August 1. Spring admission due date is January 4.

# PERSONAL DATA:

Basic BSN

RN to BSN

DNP

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last Middle First

Date of Birth: RU ID #

Local Address Telephone Number: ( ) \_

Permanent Address Telephone Number: ( ) \_

Other contact information (cell phone, pager) \_\_ Radford e-mail address:

# NEXT OF KIN:

Name Next of Kin Relationship

Address Telephone ( )

*In Case of Emergency Notify:*

Name Relationship

Phone (work) ( ) Phone (home) ( ) (cell)

# HEALTH CARE:

Name and Credentials (MD, NP, etc) of primary provider:

Address Telephone ( ) \_

Health Insurance Company \_ Policy No.

Health Insurance Company Member Services Telephone number ( )

# HEALTH HISTORY:

1. Check boxes to indicate whether you have (or had in past) these problems. Provide details of positive answers on the back of this sheet. We may request that you have your health care provider send further information after we review your answers.

|  |  |  |  |
| --- | --- | --- | --- |
| YES | NO | DATE | CONDITION |
|  |  |   | Anemia (including sickle cell anemia) |
|  |  |   | Asthma |
|  |  |   | Bleeding disorder |
|  |  |   | Blindness (complete or partial) |
|  |  |   | Cancer (including leukemia, Hodgkin’s Disease) |
|  |  |   | Colitis, ulcerative |
|  |  |   | Cystic Fibrosis |
|  |  |   | Diabetes |
|  |  |   | Epilepsy or other seizure disorder |
|  |  |   | Glaucoma |
|  |  |   | Hearing loss (complete or partial) |
|  |  |   | Heart enlarged |
|  |  |   | Heart murmur |
|  |  |   | Heart valve problem |
|  |  |   | Hepatitis |
|  |  |   | High blood pressure |
|  |  |   | Hypoglycemia |
|  |  |   | Infectious mononucleosis in past 6 months |
|  |  |   | Inflammatory bowel disease |
|  |  |   | Kidney infection or stone |
|  |  |   | Migraine headache |
|  |  |   | Pneumonia |
|  |  |   | Rheumatic Fever |
|  |  |   | Rheumatoid arthritis |
|  |  |   | Stomach ulcers |
|  |  |   | Substance abuse (alcohol and/or drugs) |
|  |  |   | Thyroid trouble |
|  |  |   | Tuberculosis |
|  |  |   | Emotional/Psychiatric problems |
|  |  |   | Other (describe below) |

1. Name any illness or health condition for which you are CURRENTLY under treatment
2. If you have been hospitalized, state:

Date Name & Address of Hospital Name of Physician Diagnosis

1. List any medicine, food, or environmental substance to which you are ALLERGIC

# CURRENT HEALTH INFORMATION:

1. List any **medications** you are now taking. Include drug name, dose and reason for taking the drug.

# TUBERCULOSIS SCREENING (required)

**(TINE Test is NOT acceptable)**

# You must have either PPD Two-Step Tuberculosis Skin Test (TST) or Quanteferon Gold (QFT-G)

**The CDC (2005) and Occupational Health and Safety Administration (OSHA, 1994) require that a two-step baseline TST or Quanteferon Gold (QFT-G be performed on students/health care workers.**

**Two-step PPD testing consists of an initial TST and, if that result is negative, a second TST is administered 1-3 weeks after the first. To be valid, each TST reaction must be read within 48-72 hours following administration. The test must be read by a RN, MD, or qualified health professional. If, during the past 12 months, a TST was administered and read within 48-72 hours, it will be accepted as the first-step of the two-step process if proper documentation can be provided**.

**Students have the option to do the Quanteferon Gold (QFT-G) which is a serology test. PPD Tuberculosis Skin Test (TST) 2 Step Results:**

1st Step: LF RF Date: Given by: Read by: Date:

PPD TB Skin Test was Negative/Positive (circle one). If positive: Measurement of induration 2nd Step: LF RF Date: Given by: \_ Read by: Date:

PPD TB Skin Test was Negative/Positive (circle one). If positive: Measurement of induration

**OR**

**Quanteferon Gold (QFT-G):**

Negative/Positive (circle one). Signature Date

Students with a previous Positive PPD skin test are not required to have a TST repeated. Documentation of positive PPD is required and ***A copy of the radiologist report of the chest x-ray must be submitted with this health form.***

Students testing Positive, without a previous Positive PPD, must have a chest x-ray done***.*** Documentation of positive PPD is required and ***A copy of the radiologist report of the chest x-ray must be submitted with this health form.****.*

PPD was Positive and a Chest x-ray was done on and the results are :

□ Negative □ Positive

***Students testing positive with the 2 step TB skin test or Quanteferon Gold (QFT-G) needs to take INH* medication as**

***prophylaxis. If currently on INH or if INH treatment has been completed, please provide documentation.***

If chest x-ray is negative, a repeat chest x-ray is not required unless symptoms develop that could be attributed to tuberculosis. EXAMINER’S SIGNATURE DATE

# CERTIFICATE OF IMMUNIZATION - The immunizations listed below are in accordance with recommendations from the: Advisory Committee on Immunization Practices, American Academy of Pediatrics, and American Academy of Family Physicians (2003). Please access the following source for further information on vaccines: CDC National Immunization Program web site [www.cdc.gov/nip](http://www.cdc.gov/nip)

|  |  |
| --- | --- |
| IMMUNIZATIONS | VACCINE DOSES ADMINISTERED |
| TETANUS, DIPTHERIA, and ACELLULAR **PERTUSSIS(Tdap)****VACCINATION Tdap replaces a single dose of Td for adults aged 19–64 years who have not received a dose of Tdap previously. All students are required to produce documentation of adult Tdap vaccination before entrance into****Radford University School of Nursing.** |  /\_ /\_ Mo Day Yr | **Tdap replaces a single dose of Td for adults aged 19–64 years who have not received a dose of Tdap previously. All students are required to produce documentation of adult Tdap vaccination before entrance into****Radford University School of Nursing.** |
| Meningococcal Conjugate |  /\_ /\_  | **Students are required to have the Meningococcal Conjugate** |
| Vaccine (MCV4) |  | Mo | Day | Yr | **Vaccine (MCV4)** |
| MCV4 Booster |  /\_ /\_  | **Meningococcal Conjugate Vaccine (MCV4) Booster is** |
|  |  | Mo | Day | Yr | **recommended if the original vaccine date was greater than 5** |
|  |  | **years.** |
| HEPATITIS B VACCINE | 1) | Mo | /\_Day | /Yr | 2) | Mo | /\_Day | /\_Yr | 3) | Mo | /\_Day | /\_Yr |
| MEASLES, MUMPS, | VACCINE | Have 2 Vaccines:1. OR have Serological Confirmation of Measles Immunity

/\_ /\_Mo Day Yr 1. AND Serological Confirmation of Rubella Immunity

/\_ /\_Mo Day Yr |
| RUBELLA (MMR) | 1) | /\_ / |
|  |  | Mo | Day | Yr |
| If born before 1957, only one |   |
| dose is required. If born | 2) | /\_ / |
| during or after 1957, both |  | Mo | Day | Yr |
| doses are required. |   |
| VARICELLA ZOSTER | VACCINE | OR |  Serological Confirmation of Immunity**(Must attach a copy of the Lab Report)** /\_ / Mo Day Yr |  |
| You either get Two (2) doses | 1) |  /\_ /\_  |
| for persons who are |  | Mo | Day | Yr |
| susceptible. |  |
| **OR** | 2) |  /\_ /  |
| The Serological Confirmation |  | Mo | Day | Yr |
| of Immunity |  |
| **Cannot State Had Disease** |  |

Licensed Health Provider Signature Licensed Health Provider Printed Name

Date Phone No.

Address

# \*MEDICAL EXEMPTION:

□ DPT  Td  Tdap  Polio  MMR  Hepatitis B Series  Varicella zoster

As specified in Article 22.1-271.2C. (II) of the Code of Virginia, I certify that administration of the vaccine(s) designated above would be detrimental to this student’s health.

The vaccine(s) is (are) specifically contraindicated because This contraindication is  permanent (or)  temporary and expected to preclude immunization until Physician’s or Health Department Official Signature Date Phone No.

# PHYSICAL EXAMINATION (to be completed by primary provider):

1. HEIGHT WEIGHT
2. BLOOD PRESSURE PULSE RESP TEMP

2. Please indicate any abnormalities in the following and describe findings at right:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| YES | NO | Skin | YES | NO | Heart |
|  |  | Endocrine |  |  | Lungs |
|  |  | Lymph |  |  | Abdomen |
|  |  | Eyes/Vision |  |  | Genitals |
|  |  | Ears/Hearing |  |  | Neurological |
|  |  | Nose/Smell |  |  | Mental Health |
|  |  | Mouth/Throat Neck/Thyroid Breasts |  |  | Emotional Stability |

□  Other

1. Do you recommend any limitations to physical activities? Yes  No 

If yes, specify in detail\_

1. In your professional opinion, do you think this student has an adequate state of physical and mental health to function in a clinical nursing program? Yes  No 

If no, specify your concern(s)

1. General Comments:

***Attention Examiner: Your signature below indicates that you have reviewed this entire document***

EXAMINER’S SIGNATURE DATE

EXAMINER’S PRINTED NAME

ADDRESS\_

TELEPHONE

1. STUDENT’S SIGNATURE DATE