



# LAKEVIEW

## COLLEGE OF NURSING

ADAPTABILITY · CARING · EXCELLENCE · INTEGRITY

Student's Name			Birth Date		
Last	First	Middle	Month	Day	Year

**IMMUNIZATIONS:** To be completed by health care provider. Note the month/day/year for *every* dose administered. The day and month is required if you cannot determine if the vaccine was give *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine/Dose	1			2			3			4			5			6			
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																			
Diphtheria and Tetanus (Td)																			
Inactivated Polio (IPV)																			
Oral Polio (OPV)																			
Hepatitis B (HB)																			
Varicella (Chickenpox)				<input type="checkbox"/> DISEASE CONFIRMED BY PHYSICIAN'S RECORD <input type="checkbox"/> IMMUNITY CONFIRMED BY BLOOD TITER				DATE OF ILLNESS ___/___/___ DATE OF TEST ___/___/___				(ATTACH COPY)							
Combined Measles, Mumps and Rubella (MMR)				TWO DOSES OF MMR VACCINE SEPARATED BY MORE THAN ONE MONTH AND GIVEN ON OR AFTER THE FIRST BIRTHDAY IS REQUIRED TO IMMUNIZE AGAINST MEASLES, MUMPS, AND RUBELLA.															
Measles (Rubeola)				<input type="checkbox"/> BORN PRIOR TO 1957; EXEMPT STATUS WITH PROOF OF AGE.															
Rubella (German or 3-day measles)				*BLOOD TITER GREATER THAN 1:10 OR THE SCREEN MUST BE POSITIVE.. IF NEITHER, THE STUDENT MUST RECEIVE THE MEASLES, MUMPS, AND RUBELLA (MMR) VACCINE.															
Mumps				<input type="checkbox"/> IMMUNITY CONFIRMED BY ELISA, EIA, OR RADIAL HEMOLYSIS ANTIBODY TEST.															
Tuberculosis (TB)				A TWO-STEP MANTOUX (5 TU INTRADERMAL PPD) <b>OR</b> CHEST X-RAY IS REQUIRED WITHIN ONE YEAR OF STARTING THE NURSING PROGRAM. IF MANTOUX TEST IS POSITIVE, A NEGATIVE CHEST X-RAY REPORT MUST BE DOCUMENTED AND THE STUDENT WILL BE REQUIRED TO SUBMIT AN ANNUAL TB EVALUATION (FORMS ARE AVAILABLE IN THE REGISTRAR'S OFFICE.)															

**ALTERNATIVE PROOF OF IMMUNITY**

1. **Clinical diagnosis is acceptable if verified by physician.** \*(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

\*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA see above Physician's Signature

2. **Laboratory confirmation** (check one)  MEASLES  MUMPS  RUBELLA  HEPATITIS B

\*MUST ATTACH COPY OF LAB RESULT WITH DATE OF TEST

**\*(Complete Both Sides)\***

**HEALTH HISTORY TO BE COMPLETED BY STUDENT**

ALLERGIES (Food, drug, insect, latex, other)			MEDICATION (List all prescribed or taken on a regular basis.)				
Diagnosis of asthma?	Yes	No	Indicate Severity	Eye/Vision problems? _____	Yes	No	Indicate Severity
Birth defects?	Yes	No		<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts			
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Ear/Hearing problems?	Yes	No	
Diabetes?	Yes	No		Bone/Joint problem/Injury/Scoliosis?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		Loss of function of one of paired organs? (eye./ear/kidney)	Yes	No	
Seizures? What are they like?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Heart problem?	Yes	No		Surgery? (list all) When? What for?	Yes	No	
High blood pressure?	Yes	No		Serious injury or illness?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Foot/Back Problems	Yes	No	
Other concerns or comments on any yes answers?							
Information may be shared with appropriate personnel for health and educational purposes.							
Student Signature: _____				Date: _____			

**ENTIRE SECTION BELOW TO BE COMPLETED BY MD/DO/APN/PA**

**DRUG SCREENING** A negative 4-panel (THC, Cocaine, Opium, Barbiturates) URINE DRUG SCREEN REPORT MUST BE ATTACHED TO THIS FORM AND REMAIN ON FILE.       Copy Attached      Results \_\_\_\_\_      Date \_\_\_\_\_

Blood Sugar      Results \_\_\_\_\_      Date \_\_\_\_\_

Total Cholesterol      Results \_\_\_\_\_      Date \_\_\_\_\_

ALT      Results \_\_\_\_\_      Date \_\_\_\_\_

Physical examination requirements		Height	Weight	Blood Pressure		
System Review	Normal	Comments/Follow-up/Needs		System Review	Normal	Comments/Follow-up/Needs
Skin				Endocrine		
Ears				Gastrointestinal		
Eyes				Genito-Urinary		
Nose				Neurological		
Throat				Musculoskeletal		
Mouth/Dental				Spinal Examination		
Cardiovascular/HTN				Nutritional Status		
Respiratory				Mental Health		

**EMERGENCY ACTION** e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem      Yes  No  If yes, please describe.

Physician/Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print: Physician's/Health Provider's Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_

I hereby give my permission to release any and all information contained in this record to the appropriate health officials as may be required by the Illinois Department of Public Health and/or the clinical facility at which I will be assigned for education. I also understand that I am responsible for the integrity of my student health record.

STUDENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_