APPENDIX A

Rudy School of Nursing and Health Profession
Health Requirement Document

Please note this document is required prior to Practicum Experience

NOTE TO HEALTH CARE PROVIDER: Health examination form may be completed by a physician, nurse practitioner or a licensed physician's assistant.

_____

Last Name First MI

HomeAddress_____

Street City State Zip Code

_____ _____ ___ _____ _____

Date of Birth Social Security No. Sex Marital Status Home Phone Cell Phone

_____

Name of Health Insurance Company & Group/Policy Number(s)

_____

PAST MEDICAL/SURGICAL HISTORY

Have you had surgery? List surgery dates.

_____

_____

Have you been treated for any serious illness? Give details_____

Are you presently on any medication? If so, list medication(s)._____

Have you been treated for any psychological/emotional problems? Give details.

_____

Is there a family history of a bleeding disorder, cancer, hypertension or diabetes? List and state relationship.

_____

Do you have any current health problems/limitations that will affect your ability to function as a nursing student? Give details

_____

CHILDHOOD DISEASES

Have you ever had:

MUMPS: Yes No CHICKEN POX: Yes No

SCARLET FEVER: Yes No

MEASLES: Yes No DIPTHERIA: Yes No

GERMAN MEASLES: Yes No

PHYSICAL EXAMINATION:

Age_____ Height_____ Weight_____ Blood Pressure_____

	Normal	Abnormal	Comments
Eyes	_____	_____	_____
Ears	_____	_____	_____
Nose and Throat	_____	_____	_____
Sinuses	_____	_____	_____
Mouth and Teeth	_____	_____	_____
Chest	_____	_____	_____
Heart	_____	_____	_____
Abdominal Viscera	_____	_____	_____
Endocrine Viscera	_____	_____	_____
Nervous System	_____	_____	_____
Lymphatic Glands	_____	_____	_____
Orthopedic Defects	_____	_____	_____

TB SKIN TEST Date _____ TB SKIN TEST RESULT _____ Date Read: _____
CHEST X-RAY (if positive skin test): Date_____ Results_____

Examiner's Signature_____ Date_____

IMMUNIZATIONS/TITERS REQUIRED

HEPATITIS B VACCINE	DATE	HEALTH CARE Provider's Initial
Dose # 1	_____	_____
Dose # 2 (to be given 1 month after the 1st injection)	_____	_____
Dose # 3 (to be given 6 months after the 1st injection)	_____	_____
TETANUS (within the last 10 years)	_____	_____

**MUMPS TITER (attach copy of lab report)
**RUBEOLA (Red Measles) TITER (attach copy of lab report)
**RUBELLA (German Measles) TITER (attach copy of lab report)
**VARICELLA TITER (attach copy of lab report)
**HEPATITIS B TITER (attach copy of lab report)

ADDITIONAL INFORMATION

_____ _____
Signature of Graduate Online Learner Date