Bethel University School of Nursing
HEALTH FORM – NEW/TRANSFER STUDENTS

STUDENT NAME: _____ ID #:_____ SCHOOL YEAR: _____

1. IMMUNIZATION STATUS

A. **Tdap Adacel (Tetanus-Diphtheria-Pertussis)**
Must be received within past ten years. **DATE:_____**

B. **MMR** (Measles, Mumps, Rubella, Rubeola) **(TWO Vaccines)** **DATE: 1_____2_____**

C. **VARICELLA** (Chicken Pox)
1. Report of Immune Titer (attach copy of IgG titer) **OR** **DATE: _____**
2. Dates of **TWO** Varicella Vaccines **DATE: 1_____2_____**

D. **HEPATITIS B – Series of THREE Vaccines**
Series must be started prior to starting clinicals. **DATE: 1_____2_____ 3_____**

2. ANNUAL TUBERCULOSIS SCREENING (Mantoux or PPD)

A. **Skin Test Date and Results in Millimeters (MM)** **DATE:_____Results:____**
(Must be within six months prior to starting clinical.)

Or

B. **QuantiFERON-TB Gold Test** (attach copy of results) **DATE:_____Results:_____**

Or

C. If Skin Test is positive, a negative **Chest X-Ray is required** (attach copy) **DATE:_____**
(Chest x-ray must be within 6 months of entering the nursing program)

3. ANNUAL FLU SHOT required during fall semester (documentation required) **DATE:_____**

4. EMERGENCY CONTACT NAME/NUMBER(REQUIRED):_____

5. Student Health Insurance (REQUIRED). Include Company Name/Policy Number_____
_____(attach copy of insurance card)

6. HEALTH CARE PROVIDER STATEMENT: Must be completed, dated, and signed.

This is to certify that I am acquainted with the health status of the above named either by virtue of my role as his/her personal health care provider, or by means of a recent physical exam and appropriate laboratory data enabling me to state that he/she is in good physical health and free of communicable disease.

Is there a history, or does the student *currently* have any of the following medical conditions that may prevent the safe completion of the duties of a nursing student during clinical experiences?

___ Back Injury ___ Lifting Restrictions ___ Uncontrolled Seizures
___ Uncontrolled Diabetes ___ Uncontrolled Asthma ___ Vision Difficulties (other than glasses)
___ Hearing Difficulties ___ Latex Allergy ___ Uncontrolled Hypertension
___ Other (list) _____Explain:_____

Any chronic health concerns the School of Nursing should be aware of? _____

I find this student to be in good health and free from a health impairment which may pose potential risk to patients while attending clinicals or performing client care activities.

_____ YES _____ NO Additional information may be added on the back.

HEALTH CARE PROVIDER

NAME (PRINT): _____ SIGNATURE: _____

PHONE #: _____ DATE: _____