Bethel University School of Nursing

HEALTH FORM – RETURNING STUDENTS

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

1. ANNUAL TUBERCULOSIS SCREENING (Mantoux or PPD)

A. **TB Skin Test Date and Results in Millimeters (MM)**
DATE: _____ MM_____

Or

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

Or

C. If TB Skin Test is positive – A negative **Chest X-Ray required** (submit copy of results to the School of Nursing). (Once documentation of a negative chest x-ray is received, the TB Screening Questionnaire must be completed annually). A change in health status may indicate the need for a repeat chest x-ray.
DATE: _____

2. ANNUAL FLU SHOT required during fall semester (documentation required):_____

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

4. Student Health Insurance REQUIRED. Include Company Name/Policy Number:_____
_____**(attach copy of insurance card)**

5. 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 this 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: _____