TRINITAS SCHOOL OF NURSING

STUDENT HEALTH RECORD

Please complete this form to the best of your ability and bring it to your Physician, Nurse Practitioner or Physician's Assistant for your physical examination.

Make a copy of your completed Health Record and submit the copy to our Director of Health, Mrs. Stansfield in Room 337, or the School Administrative office in Room 324.

RETURN TO:

Mrs. Patricia Stansfield
Director of Student Health
Trinitas School of Nursing
40 West Jersey Street
Elizabeth, New Jersey 07202
908.659.5148
stansfield@ucc.edu

TRINITAS SCHOOL OF NURSING

STUDENT HEALTH RECORD

Name (Last) _____ **(First)** _____ **Middle Initial** _____

Fall Semester _____ **Spring Semester** _____ **UCC ID #** _____

Course: NURE _____

Birth Date _____ **Male** _____ **Female** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone# _____ **Cell #**_____ **Work #** _____

STUDENT: Please check all items that apply to you:

_____ **Allergies**	_____ **High blood pressure**
_____ **Asthma**	_____ **Migraine or severe headaches**
_____ **Arthritis or Rheumatism**	_____ **Hepatitis**
_____ **Back Injuries**	_____ **Bronchitis or Chronic cough**
_____ **Chest pains**	_____ **Psychiatric disorder**
_____ **Chronic back pain**	_____ **Heart disease**
_____ **Convulsions**	_____ **Tuberculosis**
_____ **Diabetes**	_____ **Surgery**
_____ **Dizzy spells or fainting**	_____ **Epilepsy**
_____ **Hearing problems**	_____ **Any other serious illness**

State details for all items check above: _____

_____

_____

_____

List present medications: _____

_____

_____

I certify that to my knowledge I have had no injury, illness or ailment other than specified and permit the examining Health Care Provider to submit a medical report including test results to Trinitas School of Nursing.

_____ _____

Signature **Date**

Name: _____ Date: _____

TRINITAS SCHOOL OF NURSING --- STUDENT HEALTH RECORD

TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISANT

Weight _____ Height _____ Pulse _____ Resp. _____ B/P _____

PHYSICAL FINDINGS

General Appearance	
Skin	
Hair	
Eyes	**Visual Acuity: Without** Correction, Right _____ Left _____ **With** Correction, Right _____ Left _____
Ears	**Hearing Acuity:** Right _____ Left _____
Nose	
Mouth	
Throat/Neck	
Respiratory	
Cardiovascular	
Breasts/Axilla	
Abdomen/Hernia	
Genitalia	
Musculoskeletal	
Neurological	
Psychological	
Endocrine	
Lymph Nodes	
Hematological	

Flu Vaccine Date: _____

Two-step Mantoux # 1: Date: _____ Result: _____ mm Interpretation ( ) Negative ( ) Positive

Mantoux #2: Date: _____Result: _____mm Interpretation ( ) Negative ( ) Positive

Quantiferon-TB Gold Blood Test Results ( ) Negative ( ) Positive

If Positive: Date Chest X-Ray _____ Chest X-Ray Result _____
Treatment _____

I have examined _____ (student) and found no indication of any disease or condition which might affect the health and safety of the student or the health and safety of the clients whom the student may provide care to. This student is able to fully participate in the clinical rotation.

Signature: _____ Date: _____
(Health Care Provider)

Name of HCP (PLEASE PRINT) _____
Address _____ City _____ State _____
Phone # _____ Fax _____
MD/NP/PA STAMP:

_____

Name: _____ Date: _____

TRINITAS SCHOOL OF NURSING -- STUDENT HEALTH RECORD

TO BE COMPLETED BY HEALTH CARE PROVIDER

A COPY OF THE ACTUAL LABORATORY TITER RESULTS MUST BE SUBMITTED WITH THIS FORM

Rubeola Titer _____ { } Immune
{ } Non-Immune: Vaccine required Date Given _____

Mumps Titer_____ { } Immune
{ } Non-Immune: Vaccine required Date Given _____

Rubella Titer_____ { } Immune
{ } Non-Immune: Vaccine required Date Given _____

Varicella Titer_____ { } Immune
{ } Non-Immune: Vaccine required Date Given _____

HBsAb Titer_____ { } Negative: If Negative Vaccination Recommended or Declination signed
{ } Positive

HBsAg Titer_____ { } Negative
{ } Positive: If Positive MD Counseled and Cleared Date _____

Hepatitis C_____ { } Negative
{ } Positive; if positive, cleared by MD, Date: _____

Quantiferon-TB Gold (if applicable) { } Negative
{ } Positive: If Positive MD Counseled and Cleared Date _____

If Hepatitis B Vaccine Series is/has been given list: Date # 1 _____

Date #2 _____

Date #3 _____

Signature _____ *Date* _____

(Health Care Provider)

Hepatitis B Virus Vaccine Declination

Due to personal, medical or religious reasons, I am requesting that TRINITAS SCHOOL OF NURSING Waive the health requirement for immunization against Hepatitis B. I am aware of the health risks of this disease, the mode of transmission, and possibility of exposure to Hepatitis B to health care professionals.

_____ _____

Student Signature *Date*

10.10.17