

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 Health Nurse, Mrs. Stansfield in Room 337, or the School Administrative office in Room 324.

RETURN TO:

**Mrs. Patricia Stansfield
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 ASSISTANT

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: _____ Declination form for annual flu vaccine attached and signed: _____

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

Mantoux #2: Date: _____ Result: _____ mm Interpretation () 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 RESULT 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

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

HBsAg Titer _____ { } 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 _____
(Health Care Provider)

Date _____

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

Date: **Declination of Annual Influenza Vaccine**

Student's Name: _____ Date of Birth: _____

Course: _____ UCC Email: _____ Phone #: _____

I acknowledge that I am aware of the following facts:

- Due to my occupational exposure, I may be at risk of acquiring influenza infection.
- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect patients from influenza, its complications, and death.
- If I contracted influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients and others.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- Fever or muscle aches can occur but these symptoms do not mean that you have the "flu". Because the vaccine is "inactivated".
- Although the influenza vaccine is made in eggs and some people are severely allergic to eggs, the quantity of egg proteins in the vaccine is insufficient to cause a severe allergic response.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in healthcare facilities, my classmates, faculty, family, and/or my community.
- I have received education about the effectiveness of the influenza vaccination, as well as the adverse events.
- I also have been given the opportunity to be vaccinated with influenza vaccine, at no charge to me. However, I decline the influenza vaccination at this time.
- With declining the influenza vaccine, I will/**may** be prohibited from participating in clinical rotation, hence clinical failure for the course. See Student Handbook for more details.
- While TRMC, and therefore TSON still allow for declination based on religious exemption, many institutions across the country are no longer accepting this exemption for those who work within the clinical setting. Any student who seeks a declination for religious exemption may be required to provide additional information and will be required to wear a surgical mask at all times during the influenza season when coming within 6 feet of patients.
- Students should be aware that in certain areas/clinical sites (particularly pediatrics), the contracted institution may not be able to accommodate unvaccinated students. TSON would have no control over this directive.

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons.**Please check which applies to you declining the flu shot:**

Medical Reasons – **Documentation is required to be attached to this form.** (Rx or on licensed health care provider's letterhead only)

Religious reasons (Consultation & Signature approval from SON Dean) _____

Student Signature/Date_____
Witness/Date