Holy Name Medical Center
Sister Claire Tynan School of Nursing

www.holyname.org/schoolofnursing

STUDENT HEALTH RECORD

Name (Last)_____(First)_____Middle Initial _____

Birth Date_____ Gender Orientation_____

Address _____

City_____State_____Zip Code _____

Home Phone#_____Cell #_____Work # _____

Personal email address_____

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**
_____ Chronic pain disorder	**_____ Tuberculosis**
_____ Diabetes	**_____ Surgery**
_____ Dizzy spells or fainting	**_____ Seizure Disorder**
_____ 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 disorder other than those specified above and permit the examining Health Care Provider to submit a health report including test results to the Holy Name Medical Center Sister Claire Tynan School of Nursing.

_____ _____

Student's Signature **Date**

Name: _____ Date: _____

Holy Name Medical Center Sister Claire Tynan School of Nursing Student Health Record

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER

Weight_____ **Height**_____ **Pulse**_____ **Resp.**_____ **B/P**_____

PHYSICAL EXAMINATION 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	

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 clinical activities without restrictions.**

Signature:_____ **Date:**_____
(Health Care Provider)

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

_____

Name: _____ **Date:** _____

Holy Name Medical Center Sister Claire Tynan School of Nursing Student Health Record

TO BE COMPLETED BY HEALTH CARE PROVIDER

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 _____

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

Tetanus Vaccination Date given:_____

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 Holy Name Medical Center Sister Claire Tynan 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***