LOEWENBERG SCHOOL OF NURSING
HEALTH EXAMINATION FORM (FORM 003)

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SECTION I: To be completed by STUDENT:

Name:_____ DOB:_____
Address:_____ Phone (H): _____
_____ Phone (C): _____

Health History: Please complete the following information:

	No	Yes	If Yes, Explain		No	Yes	If Yes, Explain
Recent weight loss or gain				Indigestion, nausea, vomiting, diarrhea, constipation			
Fatigue, fever, sweats				Frequent bladder infections or excessive urination			
Difficulty with vision or hearing				Abnormal menses or vaginal discharge (female)			
Difficulty swallowing, hoarseness, sore throat				Penile discharge or testicular lumps (male)			
Swollen glands or lumps in neck, groin or axilla				Numbness, weakness in arms or legs			
Dizziness, fainting				Neck or back pain			
Chronic cough, wheezing, short of breath				Excessive bruising or bleeding			
Cold sores				Depression, anxiety, insomnia			
Chest pain, palpitations or ankle swelling				Frequent or unusual headaches			

Please answer yes or no to the following:

_____ Since your last PPD review have you worked in a location where patients with active TB received care or services?
_____ Since your last PPD have you lived or had close contact with someone who has TB disease?
_____ Since your last PPD, have you had an abnormal chest X-ray?
_____ Since your last PPD, has a healthcare practitioner told you that your immune system isn't working or can't fight infection?
_____ Since your last PPD, have you traveled outside the USA? If so, where?
_____ Since your last PPD, have you had any of the symptoms listed below for more than 3 weeks at a time?

( ) Persistent cough ( ) Hoarseness ( ) Excessive sweating at night
( ) Excessive weight loss ( ) Excessive fatigue ( ) Coughing up blood
( ) Persistent fever ( ) None of the above

Student Signature: _____ Date:_____

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SECTION II: To be completed by licensed health care provider (e.g., physician, certified nurse practitioner, physician assistant)

Previous medical and surgical history:

Pertinent family history:

Pertinent social history:

Under current medical care: _____ NO _____ Yes If YES, please explain:

Current medication: Allergies:

Does this individual have any physical or mental conditions, disabilities or medical limitations that would prohibit the individual from functioning in the capacity of a Registered Nurse?

_____ No _____ Yes If YES, please explain

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PHYSICAL EXAMINATION

Wt ____ Ht _____ B/P_____ Pulse_____ Vision: OS_____OD_____ OU_____

	Check if WNL	Abnormality noted and comments
General appearance		
Skin, hair, nails		
Eyes (including vision screening)		
Ears (including hearing screening)		
Nose, throat, mouth, teeth		
Neck, thyroid, nodes		
Lungs		
Heart		
Abdomen		
Breasts		
Musculoskeletal		
Neurological		
Reproductive*Pelvic exam/Pap not required		

LABORATORY TESTING AND IMMUNIZATION REQUIREMENTS –

The Hepatitis B series MUST be completed 1 month prior to beginning a clinical practicum experience. If any of these titers do not show immunity, the appropriate vaccine(s) or boosters are to be administered unless medically contraindicated.

Required Immunizations	**mo./ day/**	**mo./day /**	**mo. / day /**	**mo. /day/ year**
• DPT or Td (Diphtheria-Pertussis-Tetanus or Tetanus-Diphtheria)	#1	#2	#3	#4
• Td (Tetanus-Diphtheria)				
• Tdap (Tetanus-Diphtheria-acellular Pertussis) ***Within 8 years** **If this immunization is contraindicated please submit documentation				
• Polio				
• MMR (After first birthday)				
• Measles			* Disease Date	*** Titer Date & Result
• Mumps			* Disease Date	*** Titer Date & Result
• Rubella			* Disease Date	*** Titer Date & Result
• Hepatitis B Series (*Unless Hep. B Waiver signed)	#1	#2	#3	*** Titer Date & Result
• Varicella (chicken pox) series of two doses or immunity by positive blood titer	#1	#2	* Disease Date	*** Titer Date & Result
• Tuberculin (PPD) Test: **within past 12 mo.** Date Read				
mm induration	mm			
Chest x-ray, if PPD positive Date				
Results				
• Influenza Vaccine: **Current flu season—required for Spring admission**				

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Students must meet core performance standards for admission and progression as follows:

A. Critical thinking ability sufficient for clinical judgment.
B. Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.
C. Communication abilities sufficient for interaction with others in verbal and written form.
D. Physical abilities sufficient to move from room to room and maneuver in small places.
E. Gross and fine motor abilities sufficient to provide safe and effective nursing care.
F. Auditory ability sufficient for observation and assessment necessary in nursing care.
G. Visual ability sufficient for observation and assessment necessary in nursing care.
H. Tactile ability sufficient for physical assessment.

I have examined _____ and found the patient to be physically and emotionally fit, free of communicable diseases and able to meet the core performance standards listed above.

_____
Health Care Provider's Signature

_____
Health Care Provider's Name (Please Print)

Address: _____

_____

Phone: (___)_____Date: _____

LOEWENBERG SCHOOL OF NURSING
HEPATITIS B VACCINATION WAIVER AND RELEASE FORM
FORM 004

The hepatitis B virus (HBV) is a serious occupational risk in the nursing profession. Contact with blood and other body fluids from infected persons is the major cause of hepatitis B virus infection in nurses. In addition to infection control and deedle precautions, The Loewenberg School of Nursing and our clinical partners requires that all nursing students be vaccinated against the hepatitis B virus. Students receiving the vaccination series must provide proof of the vaccination series. A signed release form must be provided annually to The Loewenberg School of Nursing from students electing not to receive the vaccine or do not have immunity.

I understand that exposure to blood or other potentially infectious materials may put me at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

_____
Signature

_____
Print Name

_____
Date

_____
UUID Number