SOUTHEASTERN ILLINOIS COLLEGE NURSING PROGRAM
HEALTH ASSESSMENT – CLINICAL EVALUATION

Student Name: ____

IMMUNIZATIONS – *To be completed by health care provider.*

2-Step **TB SKIN TEST**	**#1 PPD skin test given**: _____ _____ _____ (Month Day Year) PPD Reading: _____ _____ _____ (Month Day Year) ___________ MM Induration **#2 PPD skin test given**: _____ _____ _____ (Month Day Year) PPD Reading: _____ _____ _____ (Month Day Year) ___________ MM Induration
TETANUS	**Tdap**: _____ _____ _____ (Month Day Year) ***OR*** **Td**: _____ _____ _____ (Month Day Year) (*Must be within 10 years*)
VARICELLA	_____ _____ _____ (Month Day Year) *Documentation of disease is not sufficient. Immunization or titer is required.*
MMR	#1 _____ _____ _____ (Month Day Year) #2 _____ _____ _____ (Month Day Year)
HEPATITIS B	#1 _____ _____ _____ (Month Day Year) #2 _____ _____ _____ (Month Day Year) #3 _____ _____ _____ (Month Day Year) **OR:** **Hepatitis B Vaccine Refusal & Acknowledgement of Risk and Release** (Southeastern Illinois College Nursing Program) Required only if student has not had the 3 series Hep B vaccines or if IgG titer shows student is non-immune. The State of Illinois and OSHA imposed laws on the health care system to require the following information. Information on the Hepatitis B virus (HBV) has been provided and the issue of vaccination has been discussed. I understand that due to my occupational exposure as a nursing student that I may be at risk of acquiring hepatitis B virus infection. I understand that I have been informed and should discuss vaccination with my physician. The hepatitis B vaccine would be administered at my own expense, not the expense of the school. At this time I choose not to be vaccinated and understand that I continue to be at risk without the vaccination. ______________________ Date ______________________ Student Signature

IgG TITERS - ***To be completed by health care provider****. Rubella titer is required. The others are only mandatory if there is no record of immunization.* ***Attach Lab Report With Results of Each Titer Drawn.***

RUBELLA IgG Titer - REQUIRED	_______ _______ _______ (Month Day Year)	____ Immune ____ Non-Immune (**Be sure to attach lab report*)
MUMPS IgG Titer – *Required if no documentation of 2 MMRs*	_______ _______ _______ (Month Day Year)	____ Immune ____ Non-Immune (**Be sure to attach lab report*)
RUBEOLA IgG Titer – *Required if no documentation of 2 MMRs*	_______ _______ _______ (Month Day Year)	____ Immune ____ Non-Immune (**Be sure to attach lab report*)
VARICELLA IgG Titer – *Required if no documentation of Varicella vaccination.*	_______ _______ _______ (Month Day Year)	____ Immune ____ Non-Immune (**Be sure to attach lab report*)
PERTUSSIS IgG Titer – *Required if no documentation of Tdap.*	_______ _______ _______ (Month Day Year)	____ Immune ____ Non-Immune (**Be sure to attach lab report*)
HEPATITIS B IgG Titer – *Required if no documentation of 3 vaccines OR if the Refusal Form is not submitted.*	_______ _______ _______ (Month Day Year)	____ Immune ____ Non-Immune (**Be sure to attach lab report*)

Student Name: ____

HEIGHT: _________ WEIGHT:_________ BMI: ___________ BLOOD PRESSURE: ______________ PULSE:_________

SYSTEM REVIEW - To be completed by health care provider:

Normal	Abnormal	Check each item in appropriate column. (Enter N.E. if not evaluated)	Normal	Abnormal	Check each item in appropriate column. (Enter N.E. if not evaluated)
		1. SKULL, SCALP, FACE, NECK, THYROID			10. ANUS and RECTUM (prostate, if indicated) (OPT.)
		2. NOSE and SINUSES			11. ENDOCRINE SYSTEM
		3. MOUTH (tongue, gingiva, teeth)			12. G.U. SYSTEM (Pap test-optional) (OPT.)
		4. THROAT and TONSILS			13. UPPER EXTREMITIES
		5. EARS (Int. and Ext. Canals)			14. FEET (lat. Pain, infection)
		6. EYES (Pupils, E.O. M. conjunct)			15. LOWER EXTREMITIES
		7. LUNGS and CHEST (include breasts)			16. SKIN, OTHER MUSCULOSKELETAL
		8. HEART (rhythm, sounds, murmurs)			17. LYMPHATIC GLANDS
		9. ABDOMEN and VISCERA (include hernia)			18. NEUROLOGIC

I have physically examined the above named individual on this date. On the basis of the examination, I find this individual to be physically capable of performing all procedures, functions and duties common to the nursing profession without restrictions. I find this individual has no condition and is on no medication which would impair his/her abilities.

Proof of immunization to all diseases listed on this form is demonstrated by vaccination. Titer results are accompanied with lab reports showing the results. This applicant displays adequate physical and mental health to participate in an educational program in nursing.

Health Care Provider Signature: ____

Address: ______________________________________

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Date: ________________________ Phone: ____________________________