MOUNT CARMEL
College of Nursing

MOUNT CARMEL COLLEGE OF NURSING HEALTH FORM

PART I: PERSONAL DATA

This section is to be completed by the student. The information provided will be treated confidentially and will not be released without the student's consent. Please print or type information.

Program: _____Semester (if a transfer student please specify)_____

Year of Admission: _____ DOB (month/day/year) _____

Student Name: _____

Last First Former Last name

(*Circle*) Male Female

Student Address: _____

City –State- Zip Code _____

Email Address_____

Cell Phone ( ) - Home Phone ( ) -

Medical Provider Name:_____

Name of Medical Provider's Office:_____

Provider Credential: MD, NP, PA _____

Medical Provider's Address: _____

City- State -Zip Code_____

Student Emergency Contact Name: _____

Contact's Phone Number ( ) -

Relationship to Student: _____

Student Signature_____ Today's Date: _____

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Student Last name _____First name_____

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PART II: STUDENT HEALTH RECORD

The examining medical provider must complete the following part of this form. The information provided will be treated confidentially and will **not be released** without the student's consent.

1. Tuberculosis Test

a. PPD Two-step skin test 2-3 weeks apart **(include TB forms with dates)**

b. QuantiFERON gold test **(include lab report and date of test)**

c. Chest x-ray required **(official report and date of test)** for students with an active infection, positive PPD test, or history of TB

2. Measles, Mumps, Rubella

a. MMR Vaccination Date 1: _____

b. MMR Vaccination Date 2: _____

i. OR

c. Measles titer, mumps titer, rubella titer **(include lab report and date of test; 3 titers total)**

3. Varicella Immunization

a. Varicella Vaccination Date 1: _____

b. Varicella Vaccination Date 2: _____

i. OR

c. Varicella titer **(include lab report and date of test)**

4. Hepatitis B Immunization

a. Hepatitis B Surface antibody titer **(include lab report and date of test)**

OR

b. Hep B Vaccination Date 1: _____

c. Hep B Vaccination Date 2: _____

d. Hep B Vaccination Date 3: _____

5. **Tetanus, diphtheria, and pertussis**

a. Vaccination Date (must be within the past ten years) _____

6. **Influenza Immunization**

a. Vaccination Date: _____

Student Last name _____First name_____

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PART III: MEDICAL CLEARANCE

A. STUDENT HEALTH HISTORY

The examining medical provider must complete the following part of this form. The information provided will be treated confidentially and will **not be released** without the student's consent.

I. Please list and describe any pertinent medical history:

_____
_____
_____
_____
_____
_____
_____

II. Drug Allergies:

III. Current Medications (dose, indication, frequency)

Student Last name _____First name_____

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B. STUDENT HEALTH EXAM

Height _____Weight _____Blood Pressure_____

Pulse _____ BMI _____

REVIEW OF SYSTEMS: Please **circle** any symptoms the student is currently experiencing:

Constitutional	**Respiratory**	**Skin**	**Eyes**
Recent fever/sweats	*Cough/Wheeze*	*Rash*	*Change in vision*
Unexplained weight loss/gain	*Coughing up blood*	*Changing mole*	*Drainage/crusting*
Fatigue /weakness	*Shortness of breath*		*Pain/redness*

Gastrointestinal	**Neurological**	**Ears/Nose/Throat**	**Genito-Urinary**
Heartburn/reflux	*Headaches*	*Chnage in hearing*	*Pain/blood with urination*
Nausea/vomiting/diarrhea	*Numbness/tingling*	*Hay Fever /Allergies*	*Leaking/night urination*
Blood in stool		*Trouble swallowing*	*Change in sexual function*
Pain in Abdomen			

Psychiatric	**Cardiovascular**	**Musculoskeletal**	**Blood/Lymphatics**
Anxiety/stress	*Chest Pain*	*Muscle/joint pain*	*Unusual bruising/bleeding*
Depression/Suicide	*Palpitations*	*Swelling*	*Pain/swelling*
Problem sleeping	*Ankle swelling*		
ADHD			
Bipolar			

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Upon examination, please note any abnormalities/areas of concern to the following systems:

Constitutional_____

HEENT_____

Cardiovascular_____

Respiratory_____

GI _____

GU _____

Musk _____

Skin _____

Neuro _____

Other_____

Medical Provider's First and Last Name: _____

Date: _____

Medical Provider's Signature _____

Credentials: _____**NPI Number:** _____