Marshall University
School of Nursing Health
Form – MSN
Due July 15th for fall admits and December 15th for spring admits

BSN students must complete health form prior to beginning the sophomore year in the nursing program; RN option students and Graduate nursing students must complete when they are admitted to the program. Information must be updated when changes in health status warrant.

Section 1: Must be completed by STUDENTS

Name: _____ Date: _____

Student ID #: _____Program: _____

Address: _____

Phone: _____/_____/_____ DOB: _____
(home) (cell) (work)

Medical History (circle appropriate response)

Anemia	YES	NO	Kidney disease	YES	NO
Asthma	YES	NO	Liver disease	YES	NO
Back problems	YES	NO	Lung disease	YES	NO
Cancer	YES	NO	Mental/emotional problems	YES	NO
Diabetes	YES	NO	Seizure disorder	YES	NO
Fainting	YES	NO	Stroke	YES	NO
Headaches	YES	NO	Tuberculosis	YES	NO
Heart disease	YES	NO	Other (specify below)	YES	NO
Hypertension	YES	NO			

If you answered yes to any of the above please give a brief overview of your problem: _____
_____
_____
_____

Allergies: (medications, food, etc.) _____
_____
_____

Current Prescriptions Medications: _____
_____
_____

Major illnesses/injuries or hospitalizations (list dates): _____
_____
_____
_____

Marshall University

School of Nursing

Heath Form – RN to BSN

Due July 15th for fall admits and December 15th for spring admits

Section 2: **To be completed by health care provider (MD, DO, NP, PA)**

Student Name: _____ Date: _____

Examination: Please note and physical or emotional problems and current treatment.

HT: _____ WT: _____ B/P: _____ Pulse: _____ Respirations _____

_

	NORMAL	ABNORMAL	NOT EXAMINED	TREATMENT
Eyes/Vision				
Ears/Hearing				
Nose, Throat, Mouth				
Head and Sinuses				
Neck/Thyroid				
Breast				
Lungs				
Heart				
Abdomen				
Genitalia				
Musculoskeletal				
Neurological				
Vascular/lymph				
Mental/Emotional				
Endocrine				
Other				

Functional Assessment: Student must be able to perform various skills which require manual dexterity and lifting capacity. Please comment regarding their ability to perceive with and utilize the five senses, as well as lift, push, bend, walk, climb, balance, etc. _____

_____

_____

_____

To your knowledge is the student taking any medication which could affect clear thinking or performance and therefore jeopardize patient safety? NO YES

Describe: _____

_____

_____

How long have you known student? _____

Marshall University
School of Nursing
Heath Form – RN to BSN
Due July 15th for fall admits and December 15th for spring admits

Student Name: _____ Date: _____

Section 2 continued: **To be completed by health care provider (MD, DO, NP, PA)**

Based upon the history and examination, please indicate your opinion of the student's health status.

_____ Student is in excellent health with no health problems and is able to deal with the physical and mental/emotional components of a professional nursing program.

_____ Student is in very good health with minimal problems which are being treated and is able to deal with the physical and mental/emotional components of a professional nursing program.

_____ Student is in good health and while receiving treatment for problems noted previously, is able to deal with the physical and mental/emotional components of a professional nursing program.

_____ Student is in poor health and is NOT able to deal with the physical and mental/emotional components of a professional nursing program.

Date: _____ Signature (Health Care Provider): _____

Section 3: Immunization record to be completed by **appropriate health care personnel (HCP) (in some cases this may be RN)**

Student may attach copies of their immunization records to document immunity, in which case the student MUST complete that part of this form themselves and clearly mark relevant information on the form they are attaching!

Students must provide evidence of immunity to measles (rubeola), mumps, rubella and varicella unless born before 1957.

1. Measles and Rubella **(Need proof of immunization x 2 or titer)**

MMR Vaccine (2 doses) _____ **and at least 4 weeks later** _____
Date Date

OR

Titer _____ Signature of HCP: _____

Marshall University

School of Nursing

Heath Form – RN to BSN

Due July 15th for fall admits and December 15th for spring admits

Student Name: _____ Date: _____

2. Tetanus, Diphtheria, Pertussis (Need proof of vaccination)

Tdap Vaccine: _____

Signature health care personnel: _____ Date: _____

3. TST Step II Screening (TB TEST): **2 Step TB Test**

The step II test is performed in two stages. It can be done over a two-three week period but must be completed before July 15th for fall admits and December 15th for spring admits.

The first test is administered. All positive results are to be followed up by your primary care physicians before you enter nursing courses.

The second step of the TB screening process is to be performed between two weeks to three weeks after the first test but must be complete by July 15th for fall admits and December 15th for spring admits.

The second step of this screening is to reduce the likelihood that a "boosted effect" will be misinterpreted as a recent infection or new conversion. The "boosted effect" is a delay-type of hypersensitivity reaction. A positive reaction to the second test probably is a boosted reaction (indicating a past infection or BCG vaccination).

This Step II Policy is designated to reduce the potential of overestimation of new infections. The Step II testing is used for initial skin testing before your entrance to nursing school. *Thereafter, a TST will be performed annually or periodically if you have had an exposure.*

This Step II procedure must be performed even if you have had annual screening in the past.

Date of 1st TB Test: _____

Reaction and Date Read: _____

(If positive reaction noted in step 1, student must provide documentation of evaluation and/or treatment by a healthcare provider)

Date of 2nd TB Test: _____

Reaction and Date Read: _____

Signature of physician/nurse reading reaction: _____ Date: _____

Marshall University

School of Nursing

Heath Form – RN to BSN

Due July 15th for fall admits and December 15th for spring admits

Student Name: _____ Date: _____

4. Chicken pox (varicella-zoster): Need to provide **proof of immunity** by **one of the following:**

Documentation of two doses of varicella vaccine _____ _____
Date Date

OR

Titer _____ _____
Date Date

OR

Documented diagnosis of chickenpox/shingles or verification of history of chickenpox/shingles

_____

Signature of Health Care Provider _____ Date: _____

5. Hepatitis B Vaccine (a series of 3 shots is required or student is to sign waiver below)

(If the series is not completed at the time this form is submitted to the SON, it is the student's responsibility to see that this information is submitted to the record's officer as soon as possible)

Hepatitis B Vaccine _____ _____ _____
Date Date Date

Signature of Health Care Provider _____ Date: _____

OR

Titer _____ Signature of HCP: _____

OR the student can sign the waiver on next page

Marshall University

School of Nursing

Heath Form – RN to BSN

Due July 15th for fall admits and December 15th for spring admits

Section 3. Hepatitis B Vaccine Waiver: **To be completed by Student** (if applicable)

I understand that due to my exposure to blood or other potentially infectious materials as a nursing student I may be at risk of acquiring Hepatitis B. I have been given the opportunity to be vaccinated at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Date: _____ Student's Signature: _____

Section 4. **To be completed by STUDENT**

I understand that this health record has been completed as part of the requirements for enrollment in the nursing program and that it will be used by faculty and staff for that purpose. Furthermore, I understand that this health record may be required by representatives of the clinical agencies who are providing clinical learning experiences for me, or to others who are directly involved in my nursing.

Unless my written permission is given, no person beyond those indicated above, and only for the above purposes, may review this form.

I verify that the information provided is accurate to the best of my knowledge.

I further understand that it is my responsibility to update this information as changes in either my physical or mental/emotional health warrant. Failure to self-report changes in my health status as I progress thought the nursing program may result in disciplinary action and/or dismissal from the nursing program.

Date: _____ Student's Signature: _____