**Southern Connecticut State University**
**Department of Nursing**

# HEALTH ASSESSMENT FORM
***for***
**Students participating in Clinical Activities**

**COMPLETED FORM IS DUE ON OR BEFORE**

**June 30, 2011**

**PLEASE MAIL OR HAND DELIVER COMPLETED FORM TO:**

***Granoff Health Center***

## *Southern Connecticut State University*

**Student Name** _________________________ **StudentID**______________________**Date of Birth**_______________

**Address**_________________________________**City**_______________**State**______________**Zip**_________________

**Student Phone Home**_______________________**Cell**_______________________**Other**________________________

**Emerg.Contact Name** ______________________**Phone(1)**_____________________**(2)** ________________________

**TO THE EXAMINING PHYSICIAN/HEALTHCARE PROVIDER:** **Date of Exam:** ______________________

On the basis of my health assessment and physical exam: ☐ **Student denies Latex Allergy**

Student is clear to participate in clinical nursing courses *with no restrictions* (please check) ☐ **yes** ☐ **no**
IF NO, please explain the nature of the restrictions/limitations related to the delivery of patient care:

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

**IMMUNIZATION ASSESSMENT**

**Please refer to the CDC** ***Healthcare Personnel Vaccination Recommendations*** **at http://www.immunize.org/catg.d/p2017.pdf.**

***TITERS MUST BE POSITIVE PER LABORATORY STANDARD; REPORT MUST ACCOMPANY THIS FORM. If titers show student is not immune, please state plan of how non-immunity will be addressed.***

RUBEOLA (MEASLES) TITER ____________Immune? Yes ___ No ___
***May be Qualitative or Quantitative Titer Laboratory report must be attached***

*If No, include plan for or evidence of receipt of 2 doses of MMR Vaccine; refer to CDC guidelines* http://www.immunize.org/catg.d/p2017.pdf

RUBELLA (GERMAN MEASLES) TITER _______Immune? Yes ___ No ____
***May be Qualitative or Quantitative Titer Laboratory report must be attached***

*If No, include plan for or evidence of receipt of 2 doses of MMR Vaccine; refer to CDC guidelines* http://www.immunize.org/catg.d/p2017.pdf

MUMPS TITER _____ Immune? Yes _____ No _____
***May be Qualitative or Quantitative Titer Laboratory report must be attached***

*If No, include plan for or evidence of receipt of 2 doses of MMR Vaccine; refer to CDC guidelines* http://www.immunize.org/catg.d/p2017.pdf

VARICELLA (CHICKEN POX) Provide Evidence of Immunity by: ☐ physician diagnosis ***or*** ☐ titer ***or*** ☐ Lab confirmation of disease ***or*** ☐2 doses of varicella vaccine $\geq$ 28 days apart

***May be Qualitative or Quantitative Titer Laboratory or physician report of diagnosis must be attached***

TETANUS/DIPHTHERIA/PERTUSSIS (TD/TDAP) Date of last Tetanus/Td Booster ___________(date given must be within last 10yrs)

***All adults who have completed a primary series of a tetanus/diphtheria-containing product (DTP, DTaP, DT, Td) should receive Td boosters every 10 years. For adults younger than age 65yrs, a 1-time dose of Tdap is recommended to replace the next Td. For further information see*** http://www.immunize.org/catg.d/p2011.pdf

**ANNUAL ASSESSMENTS/REQUIREMENTS:**

**Hep. B SERIES**: _____________ ___________ __________
*Per protocol* 1st dose 2nd dose 3rd dose

☐ ***Student has been determined to be a non-responder and is aware of CDC recommendations for exposure to Hepatitis B surface antigen positive blood, refer to CDC guidelines*** http://www.immunize.org/catg.d/p2017.pdf

Hep. B Surface Antibody Titer _______________________Immune? Yes______No_____ **(if no, revaccinate with add'l 3 dose series)**
***$\geq$10mIU/ml is positive/Immune*** (1-2 months following Dose #3)

***Laboratory report must be attached***

**PPD 1** (Mantoux Tuberculin testing required yearly) _____________ ______________ _______________
(Unless requirements of clinical facility differ) Date Given Date Read Results

***Official report/record must be attached***

If positive PPD, list chest x-ray date: _____________ ☐ Student shows no evidence of TB symptoms
Chest x-ray date

**Influenza Vaccination** is recommended yearly; please provide evidence of vaccination per CDC protocol _____________
***Official report/record must be attached*** Date Given

________________________ ______________________________ ______________________ _________
**Healthcare Provider Print Name** **Healthcare Provider Signature** **DEA Number** **DATE**

**Address**: _____________________________________________________________**Telephone** ( ) ________- __________

Revised April 2010

**Name/Address/Other Identifying Information for Nursing Program**

Student Statement of Release

I hereby authorize ___________*Southern CT State Univ*________ to release a copy of my health record to clinical site agencies and/or to contact my Healthcare provider for clarification of information.

I understand that I must submit a completed Health Assessment form prior to participation in any clinical experiences.

I am aware that if during the course of the academic year(s) requiring my participation in clinical experiences, my health status should change in a way that would impact my ability to perform in clinical, I must notify the Director/Administrator of the program. The need for additional clearance will be determined at that time.

______________________________
Student Name (Please Print)

_______________________________ __________________
Student Signature Date