

PRE-ENTRANCE HEALTH EXAMINATION

ALL SECTIONS MUST BE COMPLETED

Last Name First Name M.I. Social Security No.

Date of Birth _____ Telephone Number _____

COMPLETE PHYSICAL EXAM:

Date _____ N = Normal or Baseline _____

TB STATUS:

PPD (Mantoux) Skin Test

Date _____ Results: Negative _____ Positive _____

If Positive: Date of Chest X-ray _____ Results _____

Isoniazid Prophylaxis: No _____ Yes _____ Dates _____

IMMUNIZATIONS:

1. Measles, Mumps, and Rubella

1st Immunization _____ MMR **OR** Measles _____ Rubella _____
2nd Immunization _____ MMR **OR** Measles _____

OR

Disease Diagnosed by Physician

Antibody Titre

Measles (Rubeola) Date _____ **OR** Date _____ Titre _____
Mumps Date _____ **OR** Date _____ Titre _____
Rubella Date _____ **OR** Date _____ Titre _____

2. Varicella

1st Immunization _____ (if under the age of 12 when immunization was administered, only one immunization is necessary)
2nd Immunization _____

OR

Disease Diagnosed by Physician

Antibody Titre

Varicella Date _____ **OR** Date _____ Titre _____

3. Tetanus/Diphtheria Date _____ (valid only if within the last 10 years)

For the following immunizations, three doses are needed for immunity:

4. Polio Date #1 _____ Date #2 _____ Date#3 _____

5. Hepatitis Date #1 _____ Date #2 _____ Date#3 _____

Titre (1B4 months following the third immunization) Date _____ Results _____

To be Completed by Health Care Provider:

In my opinion _____ exhibits positive health and is able to participate in clinical nursing experiences.

Additional Comments _____

Signature of Physician or Nurse Practitioner _____ Date _____ Telephone Number _____

Date of Eye Examination _____ Signature Ophthalmologist/Optomtrist _____

Date of Dental Examination _____ Signature of Dentist _____

This information may be released to clinical agencies participating in undergraduate nursing education.

Signature of Student

Revised 10/02

Date