

Health History, Physical Examination, and Immunization Record

To the applicant/student: Please complete this section before appointment with medical practitioner.

Personal Information

NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE: _____ DATE OF BIRTH: _____ / _____ / _____
Month Day Year

PROGRAM OF STUDY: AS in Nursing AAS in Medical Assisting AAS in Medical Office Management

To the examining medical practitioner:

This applicant is considering admission into a nursing or health science program at Kaplan University. To ensure the health and safety of patients and other health care providers while enrolled, this person will be: required to achieve in a rigorous academic program; involved in stressful situations on a one-to-one basis; called upon to work with groups of people in stressful situations; required to use effectively all sensory organs; engage in activities that require above-average manual dexterity; and required to be on his/her feet for 4 to 8 consecutive hours at one time.

Physical Examination Record

PAST HISTORY

MEDICAL:

Cardiac: _____ Diabetes: _____

Respiratory: _____ Cancer: _____

Learning Disability: _____ Hypertension: _____

Other: _____

SURGICAL: _____

FAMILY HISTORY: _____

ALLERGIES: Drug: _____ Other: _____

MEDICATIONS: _____

HABITS: _____

LIMITATIONS/SPECIAL ACCOMMODATIONS: No: ____ Yes: ____ Describe _____

Name: _____

REVIEW OF SYSTEMS/ PHYSICAL EXAM FINDINGS

EYES: _____

ENT: _____

NECK: _____

LUNGS: _____

HEART: _____

BREAST: _____

ABDOMEN: _____

RECTAL: _____

PELVIC: _____

EXTREMITIES: _____

NEURO: _____

REQUIRED LABORATORY STUDIES

1. HCT/HGB: RESULTS: _____

2. UA (dipstick): RESULTS: _____

CERTIFICATION OF HEALTH STATUS

I hereby certify that I have examined _____ and that he/she is physically and emotionally able to be enrolled as a nursing or health science student. To the best of my knowledge, on this date, I have determined that he/she is free from any health impairment that is of potential risk to patients or that might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs and substances that may alter the individual's behavior.

COMMENTS OF EXAMINER:

SIGNATURE OF EXAMINING MD/DO/NP/PA: _____ DATE: _____

TYPE OR PRINT NAME AND TITLE: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Name: _____

REQUIRED IMMUNIZATIONS:

A. MMR (Measles, Mumps, Rubella) Vaccine Two doses required for all students born after 12/31/56.

Vaccination Dates: 1. ____/____/____ 2. ____/____/____

OR individual vaccine/proof of immunity as noted below.

1. Measles (Rubeola) Vaccine Check all that apply:

q Vaccination Dates: 1. ____/____/____ 2. ____/____/____

q Documentation of positive immune titer. Date: ____/____/____
Attach copy of titer report

2. Rubella (German Measles) Vaccine Clinical history is not acceptable in place of vaccine. Check all that apply:

q Vaccination Dates: 1. ____/____/____ 2. ____/____/____

q Documentation of positive immune titer. Date: ____/____/____
Attach copy of titer report

3. Mumps Vaccine Check all that apply:

q Vaccination Dates: 1. ____/____/____ 2. ____/____/____

q Documentation of positive immune titer. Date: ____/____/____
Attach copy of titer report

B. Diphtheria, Tetanus, and Pertussis Vaccine

- Dates of primary series: 1. ____/____/____ 2. ____/____/____
3. ____/____/____ 4. ____/____/____ 5. ____/____/____
- Last booster within the past 10 years: Td, TT, or Tdap (circle one)
Date: ____/____/____

C. Polio Vaccine

- Dates of primary series: 1. ____/____/____ 2. ____/____/____
3. ____/____/____ 4. ____/____/____
- Type of vaccine: Oral (OPV)____ Inactivated (IPV)____
- Booster (optional): Date: ____/____/____
Type of vaccine: Oral (OPV)____ Inactivated (IPV)____

D. Varicella (Chicken Pox) *One of the following is required:*

q Documentation of positive varicella titer. Date: ____/____/____
Attach copy of titer report. If negative, varicella immunization required.

q Vaccine: One dose of vaccine is required prior to age 13. Two doses are required after age 13.
Vaccination Dates: 1. ____/____/____ 2. ____/____/____

Hepatitis Waiver (Decline to Receive Hepatitis B Vaccination)

- I understand that due to my clinical laboratory exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV).
- I have had an opportunity to receive information and to ask questions and understand the benefits and risks of the hepatitis B vaccination. I do not wish to receive this vaccine at this time and request that it not be given to me.
- I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

Signature of person declining vaccine

Date

Name: _____

E. **Hepatitis B Vaccine** (Three doses and positive titer required.)

Name and address where immunization was obtained:

- 1st dose Date: ____/____/____ _____
- 2nd dose Date: ____/____/____ (1 month after 1st dose) _____
- 3rd dose Date: ____/____/____ (6 months after 1st dose) _____

AND

Hepatitis B Titer (HbsAb or Anti-HBs – antibody to hepatitis B surface antigen)

Immunity demonstrated by hepatitis B titer

Date: ____/____/____ Positive/Reactive _____ Negative/Nonreactive _____

(If negative, attach copy of titer report.)

F. **Tuberculosis Skin Test (PPD/Mantoux)** Two-step TB skin test required initially; annual TB skin test required thereafter.

• Two-Step TB Skin Test

1. Step 1 (Date placed) ____/____/____ Step 1 (Date read) ____/____/____ Results: ____ mm

2. Step 2 (Date placed) ____/____/____ Step 2 (Date read) ____/____/____ Results: ____ mm

Note: Any two documented TB skin tests completed within a twelve-month period will be considered a two-step skin test.

• Annual TB Skin Test

If the two-step skin test was completed more than twelve months prior to start of class, one TB skin test within the past six months is required.

Date placed ____/____/____ Date read ____/____/____ Results: ____ mm

• History of Positive TB Skin Test : Date ____/____/____

Documentation of chest x-ray and treatment required.

• History of BCG vaccination: Date ____/____/____

TB skin test required regardless of prior BCG vaccination.

RECOMMENDED IMMUNIZATIONS:

• **Meningococcal Vaccine (Meningitis)**

Recommended for students living in college dormitories who have not been immunized previously or for college students under 25 years of age who wish to reduce their risk.

Vaccination Date: ____/____/____

• **Influenza Vaccine**

Recommended annually for health care providers.

Vaccination Date: ____/____/____

A copy of titer reports (i.e. hepatitis B, varicella, mumps, rubella, rubeola) must be provided with this form as indicated above.

SIGNATURE _____ DATE ____/____/____

Must be signed by physician or nurse

PRINT NAME _____

ADDRESS OF HOSPITAL/CLINIC OF PHYSICIAN OR NURSE VERIFYING THIS INFORMATION:

TELEPHONE NUMBER OF HOSPITAL /CLINIC: _____