

**Indiana University-Purdue University Fort Wayne  
College of Health and Human Services  
Parkview Department of Nursing  
Health Record Form**

Each applicant must submit this health record form to the Department of Nursing with his/her application.

**PROGRAM – Please circle one of the following:      BS              MS**

*STUDENTS: Please make a copy of completed form for your personal records.*

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*Please Print*

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Last Name	First Name	Middle Name	Maiden Name	IPFW ID
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**TO BE COMPLETED BY PHYSICIAN or HEALTHCARE PROVIDER (Please check one)**

\_\_\_\_\_ A. Physically able to perform essential functions of nursing, based on medical examination. Based on clinical data and testing, this individual is free from infectious disease. Not tested for HIV/AIDS or all sexually transmitted diseases.

Comments:

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\_\_\_\_\_ B. Physically able to perform essential functions of nursing, based on medical examination, with the following recommended accommodations:

Comments:

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\_\_\_\_\_ C. Physically unable to perform essential functions of nursing, based on medical examination. Based upon a high probability of substantial harm, this individual would pose a direct threat to self or others.

Signature for above documentation:

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Healthcare Professional's Signature

Date

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Print Name

Phone Number

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Address

(OVER)

**REQUIRED IMMUNIZATIONS**

<b>MMR (Measles, Mumps, and Rubella)</b>	
MMR #1 _____ Date _____	MMR #2 _____ Date _____
<b>OR</b>	
MMR Titer: _____ Date _____	Results: _____ (Immune/non-immune)
<b>TETANUS AND DIPHTHERIA (Td) (appropriate booster)</b>	
Within last ten years _____ Date _____	
<b>Varicella (Chickenpox)</b>	
Varicella #1: _____ Date _____	Varicella #2: _____ Date _____
<b>OR</b>	
Varicella Titer: _____ Date _____	Results: _____ (Immune/non-immune)
<b>OR</b>	
History of the disease _____ Date _____	
<b>Hepatitis B (3 doses)</b>	
1. _____ Date _____	2. _____ Date _____
3. _____ Date _____	
<b>OR</b>	
Hepatitis B Titer: _____ Date _____	Results: _____ (Immune/non-immune)
<b>POLIO</b> _____ Date _____	
Routine primary immunization for adults in the U.S. is <b>NOT</b> recommended. If an adult needs to be immunized E-IPV is preferred because the risk for vaccine-associated paralysis following OPV is slightly higher in adults than children. <u>Please discuss with your physician.</u>	

**TUBERCULOSIS SCREENING**

T.B. screening (Mantoux skin test or positive reaction form) is required once a year for all nursing students enrolled in clinical settings and cannot expire during a semester. [Tine test is **NOT** acceptable.]

**One Step Method for MS, BS Completion & LPN-RN Only**

For licensed RN or LPN with documented negative Mantoux result during the preceding 12 months or Two-Step Required.

**Mantoux Skin Test** Date: \_\_\_\_\_

Reading: \_\_\_\_\_

Signature: \_\_\_\_\_

**Preceding 12 months** Date: \_\_\_\_\_

Reading: \_\_\_\_\_

Signature: \_\_\_\_\_

**OR**

**Two Step Method for Generic BS**

Requires a SECOND TEST 1-3 weeks after the first one.

**1st Mantoux Skin Test** Date: \_\_\_\_\_

Reading: \_\_\_\_\_

Signature: \_\_\_\_\_

**2nd Mantoux Skin Test** Date: \_\_\_\_\_  
(1-3 weeks after 1<sup>st</sup> test)

Reading: \_\_\_\_\_

Signature: \_\_\_\_\_

**Chest X-ray** (for students who have a positive Mantoux test)

Date & Reading: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician or Health Care Provider for above documentation.

\_\_\_\_\_  
Address

**Signature for verification:**

I confirm that to the best of my knowledge the information recorded above is correct.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date