COMPREHENSIVE CLINICAL HEALTH FORM
ROCHESTER COLLEGE SCHOOL OF NURSING

To be completed by student (please print)

Name (Last, First, M.I.) _____

Birth Date:_____ Gender: ____ Female ____ Male RC ID #_____ RC email:_____

Current Medications:	**Current Allergies:**

Are you being treated for any disease, disability or condition?		Yes (Please explain)		No

*This record will become part of the student's School of Nursing file and disclosed to school officials with a legitimate interest.

I hereby represent that each answer to a question herein and all other information otherwise furnished is true and correct. I further represent that such answers and information constitute a full and complete disclosure of my knowledge with respect to the question or subject to which the answer or information relates. I understand that any incorrect or false statements or information furnished by me will subject me to disqualification at any time.

Authorization to release this medical record to Rochester College School of Nursing

Student Signature _____ Date_____

HEPATITIS B VACCINE ACKNOWLEDGMENT AND RELEASE
ROCHESTER COLLEGE
SCHOOL OF NURSING STUDENTS

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I have declined the hepatitis B vaccination at this time. I agree to release, exonerate and forever unconditionally discharge and hold harmless Rochester College, its Board of Trustees, officers, directors, employees, representatives, agents and assigns and the facility where I receive my clinical training, from any and all liability, claims or causes, known or unknown, now or hereafter arising directly or indirectly out of or relating in any way to my declining the Hepatitis B vaccinations. I acknowledge that I am placing myself and others at risk of serious illness should I contract a disease that could have been prevented through proper vaccination.

Student Name: _____
(Please Print)

Student Signature: _____

Date: _____

_____
(Signature of parent or guardian if student is a minor)

Date: _____

COMPREHENSIVE CLINICAL HEALTH FORM
ROCHESTER COLLEGE SCHOOL OF NURSING
CLINICAL EVALUATION

To be completed by health care provider

Height:_____ Weight:_____ Blood pressure:_____/_____ Pulse:_____

Normal	Abnormal	Check each item in appropriate column. Enter **NE** if not evaluated.	Normal	Abnormal	Check each item in appropriate column. Enter **NE** if not evaluated.
		SKULL, SCALP, FACE, NECK, THYROID			ANUS and RECTUM (OPTIONAL) (Prostate, if indicated)
		NOSE and SINUSES			ENDOCRINE SYSTEM
		MOUTH (tongue, gingivae, teeth)			G.U.SYSTEM (OPTIONAL) (Pap test-optional)
		THROAT and TONSILS			UPPER EXTREMITIES
		EARS (Int. and Ext. Canals)			FEET (lateral pain, infection)
		EYES (Pupils, E.O.M. conjunct.)			LOWER EXTREMITIES
		LUNGS and CHEST (include breasts)			SKIN, OTHER MUSCULOSKELETAL
		HEART (rhythm, sounds, murmurs)			LYMPHATIC GLANDS
		ABDOMEN and VISCERA (include hernia)			NEUROLOGIC

Distance vision: right 20/_____ corr. to 20/_____ left 20/_____ corr. to 20/_____

Test	Date	Results
TUBERCULIN SKIN TEST (PPD) Attach documentation of test results. CHEST X-RAY (If history of positive skin test) Attach most recent chest x-ray report (within last 5 years)	_____ _____ _____ Month Day Year	_____ MM
TETANUS (T-dap – within last 10 years)	_____ _____ _____ Month Day Year	
ATTACH LAB REPORT WITH RESULTS OF TITER OR IMMUNIZATION RECORD MUMPS IGG TITER RUBELLA IGG TITER RUBEOLA IGG TITER VARICELLA IGG TITER (chronic) Positive history of disease is <u>not</u> acceptable documentation of immunity	A COPY OF LAB RESULTS MUST BE ATTACHED. **HANDWRITTEN RESULTS WILL <u>NOT</u> BE ACCEPTED** _____ _____ _____ Month Day Year _____ _____ _____ Month Day Year _____ _____ _____ Month Day Year	 _____Immune _____Non-Immune _____Immune _____Non-Immune _____Immune _____Non-Immune
MMR Immunization **Varicella Immunization** Positive history of disease is <u>not</u> acceptable documentation of immunity	MMR #1 _____ _____ _____ Month Day Year MMR #2 _____ _____ _____ Month Day Year Varicella #1 _____ _____ _____ Month Day Year	**LAB WORK NEEDED FOR TITERS**
HEPATITIS B VACCINE – 3 Required unless student submits signed Refusal Form or proof of immunity (attach to form)	Inj # 1 _____ _____ _____ Month Day Year Inj # 2 _____ _____ _____ Month Day Year Inj # 3 _____ _____ _____ Month Day Year	Titer _____ _____ _____ Month Day Year ____ Immune ____ Non-Immune

Examining Health Care Provider: _____ **Examining Health Care Provider:_____**
Please Print **(Signature Required)**

Address:_____ City:_____ State:_____ Zip:_____

Phone: (____)________________________ Date:_______________