NURSING

Illinois Valley Community College

HEALTH INFORMATION FORM

Physical forms must be completed and uploaded into CastleBranch. All information must be filled in or this form will not be accepted. Please make a copy of your completed form for your records.

NAME:_____

ADDRESS:_____

TELEPHONE:_____ SOCIAL SECURITY#:_____-_____-_____

MARITAL STATUS:_____ SEX:_____ BIRTHDATE:_____ AGE:_____

In case of emergency, please call:

NAME:_____ RELATIONSHIP:_____

TELEPHONE: Home: _____ Work:_____

NAME:_____ RELATIONSHIP:_____

TELEPHONE: Home: _____ Work:_____

YOUR PHYSICIAN:_____ TELEPHONE:_____

ADDRESS:_____

TO THE DOCTOR: This individual is an applicant for the Illinois Valley Community College Nursing Program. The following health information is essential.

PHYSICAL EXAMINATION

Health History:

Condition	No	Yes	Treatment
Asthma	_____	_____	_____
Convulsions	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy/Seizure Disorder	_____	_____	_____
Allergies/Sensitivities	_____	_____	_____
Mental/Emotional Illness	_____	_____	_____
Physical Impairments	_____	_____	_____
Other_____	_____	_____	_____

Physical Status	Normal	Explanation of Abnormality
Neck	_____	_____
Lung	_____	_____
Heart	_____	_____
Abdomen	_____	_____
Extremities	_____	_____
Bones, Joints	_____	_____
Reflexes	_____	_____
Spine	_____	_____
Circulation	_____	_____
Vision	_____	_____

Vision Requirement: Vision is required to prepare and analyze data. Using measuring devices, assembly of small parts, visual inspection, and normal color perception are also requirements.

Hearing _____ _____

Hearing Requirement: Must perceive forced whispered voice greater than or equal to 5ft with or without hearing aid.

Other_____ _____ _____

Is this individual currently receiving medical treatment? No_____ Yes_____

If yes, explain:

List past and current medical conditions: _____

Have you ever had surgery? If yes, list all past surgical procedures: _____

List all current prescriptions, over-the-counter medicines or supplement (herbal and nutritional).

Name of Medications:	Frequency of use:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies? If yes, please list all of your allergies (i.e. medicines, food, stinging insects).

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response).

	Not at all	Several Days	Over Half the days	Nearly Every Day
Feeling nervous, anxious or on edge.	0	1	2	3
Not being able to stop/control worrying	0	1	2	3
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of >3 is considered positive on either subscale [questions 1 and 2 or questions 3 and 4] for screening purposes)

General Questions Explain "yes" answers at the end of the form.	YES	NO
Do you have any concerns that you would like to discuss with your provider?		
Has a provider ever denied or restricted your participation in sports or occupation for any reason?		
Do you have any ongoing medical issues or recent illness?		
Heart Health Questions About You.	YES	NO
Have you ever passed out or nearly passed out during or after exercise?		
Have you ever passed out or nearly passed out after sitting or lying for extended periods of time?		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you have heart problems?		
Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?		
Do you get light-headed or feel shorter of breath during exercise?		
Have you ever had a seizure?		
Bone and Joint Questions	YES	NO
Have you ever had a stress fracture or any injury to a bone, muscle, ligament, joint, or tendon that causes you discomfort now?		
Medical Question	YES	NO
Do you cough wheeze, or have difficulty breathing during or after exercise?		
Are you missing a kidney, an eye, spleen, or any other organ?		
Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus* aureus (MRSA)		
Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
Do you worry about your weight?		
Are you trying or has anyone recommended that you gain or lose weight?		
Are you on a special diet or do you avoid certain types of foods or food groups?		
Have you ever had an eating disorder?		

Explain "yes" answers here:

_____

_____

Physical Examination Form

Examination		
Height:	Weight:	BP:
Pulse:	Temperature:	Respirations:
Vision R 20/	Vision L 20/	Corrected? Y/N
Medical	**Normal**	**Abnormal Findings**
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapses [MVP], and aortic insufficiency.		
Eyes, Ears, nose, and throat • Pupils equal • Hearing		List any devices used.
Lymph nodes		
Heart • Murmurs (auscultation standing auscultation supine, and +- maneuver)		
Lungs		
Abdomen		
Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurological		
Musculoskeletal	**Normal**	**Abnormal**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		

In order to perform the job responsibilities and tasks assigned to the students in the Nursing Programs, the student must be able to:

< Perform a full range of body motion including bilateral arm, hand and finger dexterity and eye-hand coordination.

< Bend, reach, pull, push, stoop, sit and walk repeatedly throughout an eight-hour period.

< Move about freely in the limited space of the Nursing operatory.

< Demonstrate visual and auditory acuity within a normal range (with correction, if needed)

< Maintain composure when subjected to high stress levels.

< Adapt effectively to environments with high tension to ensure patient safety.

< Respond quickly in an emotionally controlled manner in emergency situations.

< Communicate in a rational and coherent manner, both orally and in writing, with individuals of all professions and social levels.

_____ This individual is physically able to perform the activities listed above and to function as a student in the nursing programs.

_____ This individual is able to function as a student in the nursing programs **WITH RESTRICTIONS**. Please indicate restrictions.

_____ _____

Physicians Signature Date

_____

Physicians Printed Name

All signatures must be that of a Health Care Provider

IMMUNIZATION/TESTING REQUIREMENTS

TB skin test

One of the following is required upon admission:

- Negative two-step skin test (1-3 weeks apart) administered within the past 3 months OR
- Negative QuantiFERON Gold blood test administered within the past 3 months OR
- Negative T-Spot blood test administered within the past 3 months OR
- If positive results, submit a clear chest x-ray administered within the past 2 years.

If your chest x-ray is more than 12 months old, a symptom free TB Questionnaire dated within the past 12 months is also required. If previous positive results, a symptom free TB Questionnaire. No yearly test will be required.

Two-Step Skin Test

Date: _____ Result: _____ Signature:_____

Date: _____ Result: _____ Signature:_____

QuantiFERON Gold Blood test

Date: _____ Result: _____ Signature:_____

T-Spot Blood Test

Date: _____ Result: _____ Signature:_____

If test is positive, please indicate:

1. Chest X-Ray Date: _____ Initial: _____
2. Symptom Free TB Questionnaire Date: _____ Initial: _____

TETANUS IMMUNIZATION:

Date: _____ (within 10 years) Signature: _____

MEASLES, MUMPS, RUBELLA VACCINE

Dose 1 date: _____ Initial: _____ Signature: _____
Dose 2 date: _____ Initial: _____ Signature: _____
Date of **disease** with Physician's signature:

Measles: Date: _____ Signature: _____

Mumps: Date: _____ Signature: _____

Rubella: Date: _____ Signature: _____

Vaccine after 12 months of age:

Mumps: Date: _____ Signature: _____
Rubella: Date: _____ Signature: _____

HEPATITIS B VACCINE:

Dose 1: Date: _____ Signature: _____

Dose 2: Date: _____ Signature: _____

Dose 3: Date: _____ Signature: _____

A completed Health Information Form must be uploaded into CastleBranch by July 31st.