LAWRENCE MEMORIAL/REGIS COLLEGE
NURSING & RADIOGRAPHY PROGRAMS

Student Health Record

All three parts of this record must be complete. Health Records must be uploaded to the Castle Branch website at https://mycb.castlebranch.com - when placing order use code LF42. Keep a copy of the information submitted for your records. Any questions please contact Castle Branch at 888-723-4263 x7196 or email Kelly McFarland at kmcfarland@lmh.edu for assistance.

Name: _____ Date of Birth: _____

Address: _____ Telephone: Home: _____

_____ Work: _____

_____ Mobile: _____

Emergency Contact: _____ Telephone: _____

Personal Physician: _____ Telephone: _____

Current health insurance and number: _____

_____

PART I – TO BE COMPLETED AND SIGNED BY STUDENT

Check if you have ever been diagnosed or treated by a physician for the following. If checked, please indicate dates and the nature of the condition next to the condition checked.

	Condition	**Explanation**
❒	High blood pressure	_____
❒	Diabetes	_____
❒	Angina	_____
❒	Heart disease/murmur	_____
❒	Rheumatic fever	_____
❒	Anemia	_____
❒	Hepatitis	_____
❒	Epilepsy or Seizures	_____
❒	Asthma	_____
❒	Stroke	_____
❒	Tuberculosis	_____
❒	Back injury	_____
❒	Nervous breakdown	_____
❒	Drug or alcohol use	_____
❒	Ulcer disease	_____
❒	Other:	_____

Please briefly explain any of the following as they apply to you (include dates):

Serious injuries: _____

_____

_____

Hospitalizations: _____

_____

Operations: _____

_____

List all medications, prescription or non-prescription, taken on a daily basis (include birth control): _____

_____

_____

List other prescription medications taken occasionally: _____

_____

_____

Allergies to medicine (state medicine and allergic response): _____

_____

_____

Other allergies (state allergy and response): _____

_____

_____

Do you smoke cigarettes? ❒ Yes ❒ No If yes, how many packs per day? _____

Do you drink alcohol? ❒ Yes ❒ No If yes, how many alcoholic drinks per week? _____

Have you ever been treated or been advised to seek treatment or counseling for drug or alcohol use? ❒ Yes ❒ No

If yes, explain: _____

_____

_____

This health record, including physical exam and immunization records, may be shared with Regis College Health Services so that student may be seen and treated at Health Services on the Weston campus. Students with Regis College Accident and Illness Insurance must allow health record to be shared with Regis College Health Services.

Check below ONLY if you do NOT allow this.

☐ I do NOT give permission to share this record with Regis College Health Services.

The foregoing statements are complete and true to the best of my knowledge. I understand that any misstatement of fact may lead to disciplinary action.

Date: _____ Signature: _____

PART II – TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

IMMUNIZATION RECORD OF _____
(Student Name)

The immunizations noted on this Student Health Record are required in order for this student to enroll in classes at Lawrence Memorial/Regis College. These requirements are necessary to comply with state regulations, CDC recommendations, and the requirements of various health care agencies where our students affiliate for clinical experiences. Failure to provide completed documentation of required immunizations will prevent enrollment in classes and clinical experiences.

A. **TETANUS – DIPHTHERIA - PERTUSSIS**

1. ❒ Completed primary series of tetanus-diphtheria immunizations: Month/Year: _____
2. ❒ Received TDaP booster: Month/Year: _____
3. ❒ If TDaP was more than 10 years ago, TD booster required: Month/Year: _____

B. **M.M.R. (Measles, Mumps, Rubella)**

1. Documentation of two doses of MMR on or after the 1st birthday, and at least 4 weeks apart; or
2. Laboratory evidence of immunity to Rubeola (Measles), Mumps, and Rubella (German Measles) as indicated by a positive titer.
3. If any titer is negative, you must have two doses of M.M.R. vaccine (at least one month apart)

❒ **Copy of titer results must be attached.**

(a) If titers are positive, no further action is required.
(b) If any titer is negative, primary immunization cannot be assumed and two doses of M.M.R. are required **at least one month apart**.
M.M.R dose 1 date: _____
M.M.R dose 2 date: _____

C. **CHICKEN POX (Varicella) :**

1. Documentation of two doses of Varicella vaccine at least 4 weeks apart; or
2. Laboratory evidence of immunity as indicated by a positive Varicella titer (IGG)
3. If varicella IGG titer is negative, two doses of Varicella vaccine required (4–8 weeks apart)

❒ **Copy of titer results must be attached.**

(a) If titer is positive, no further action is required.
(c) If titer is negative, immunity cannot be assumed and two doses of Varicella vaccine are required **(4 – 8 weeks apart**).
Varicella vaccine #1 date: _____
Varicella vaccine #2 date: _____

D. **HEPATITIS B**

1. Three doses of Hepatitis B vaccine required unless immunity is demonstrated by Hepatitis B antibody titer (HbSAB)
2. Vaccine schedule:
   1st dose: as soon as possible
   2nd dose: 1-2 months after 1st dose (minimum of 4 weeks between doses 1 and 2)
   3rd dose: 4-6 months after 2nd dose (minimum 8 weeks between doses 2 and 3; overall a minimum of 16 weeks between doses 1 and 3)

Two of the three doses of hepatitis vaccine should be completed prior to enrollment; failure to adhere to time schedule between vaccines may require re-vaccination or titer

Student must receive the complete series to be fully protected. The first two doses should have been completed prior to beginning school.

❒ Dose 1 date: _____

❒ Dose 2 date: _____

❒ Dose 3 date: _____

E. **MENINGOCOCCAL DISEASE**
Meningococcal conjugate or meningococcal polysaccharide vaccine administered within the last five years is recommended.
Date of administration: _____

F. **FLU VACCINE**
Annual flu vaccine from current flu season. Documentation of administration will be required in the Student Health Record.

Date of administration: _____

G. **TB (TUBERCULOSIS): Two-step Tuberculin Skin Test (TST) <u>required</u>: two Mantoux tests using tuberculin purified protein derivative (PPD) injections. (Tine and monovac tests are <u>not</u> acceptable). If student has a documented negative PPD skin test within one year of enrollment, a second PPD must be administered and read prior to entering a clinical facility. If the PPD skin test was not done in the 12 month period, two PPD tests must be given. The second is planted 7-21 days after the first.**

1. PPD must be "planted" (injected just under the skin) and subsequently "read" (evaluated for induration or "hardness") 48 to 72 hours after the planting. Reading results as well as the dates of planting and readings must be documented by health care provider or Registered Nurse.

   Give date and test results. Date planted: ___/___/___

   Date read: ___/___/___ Result: Positive: ❒ Negative: ❒

   If **positive result or there is a known history of positive PPD**, Chest x-ray is required with result documented a well as evidence of counseling and/or treatment and an annual symptom screen.

   Date: Month: _____ Year: _____
   Result: Positive: _____ Negative: _____

2. If **negative** result, a second TST must be planted. This should occur 7 to 21 days after the first planting and subsequently read 48 to 72 hours later by a health care provider or RN. Results of the second reading must be documented as well as the dates of the second planting and reading.

   Give date and test results. Date planted: ___/___/___
   Date read: ___/___/___ Result: Positive: ❒ Negative: ❒

3. Students are required to have annual Mantoux tests while enrolled to meet clinical agency requirements.

   (Please indicate if you have received BCG in the past: ❒ Yes ❒ No
   Indicate if born **<u>outside</u>** of the United States: ❒ Yes ❒ No)

H. **POLIO: (Strongly advised, but not required; more detailed information provided in Student Health Record)**
1. Documented completed series of polio immunizations (In the absence of polio documentation, vaccination is assumed for students who attended school in the US. Students educated outside US may be at risk unless vaccinated)

   Type of vaccine: ❒ Oral ❒ Inactivated ❒ E-IPV
   Last booster date: Month: _____ Year: _____

If documentation of polio immunization is not available and the student was **<u>not</u>** educated in the United States in the primary grades, there may be a risk to the student. This risk may occur during clinical experiences when handling babies recently immunized with polio vaccine since they may shed the virus in their stools. Health care providers are encouraged to contact the Massachusetts Department of Public Health for recommendations concerning adult polio immunization. The decision to immunize these students rests with the health care provider and the student. Documentation of vaccines given and their dates should be provided for inclusion in the students' health care record. Students educated in the United States in the primary grades, must have been immunized prior to school attendance.

HEALTH CARE PROVIDER VERIFICATION

Print Name: _____

Address: _____

Telephone: ( ) _____

Signature: _____

PART III – TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

Physical Examination

Student Name: _____

Height _____ Weight _____ Pulse _____

Blood Pressure _____

Vision: WNL _____ Wears Corrective Lenses:----------
Hearing: WNL Yes_____ NO----------

Check (4) if normal. Mark [0] if deviation from normal and give details below.

Head/Neck	❒	Eyes	❒	Abdomen	❒
Nose/Sinuses	❒	Ears	❒	Hernia	❒
Mouth/Throat	❒	Chest	❒	Genito/Urinary	❒
Teeth/Gums	❒	Lungs	❒	Pelvic	❒
Glands	❒	Heart	❒	Extremities	❒
Thyroid	❒	Breasts	❒	Joints	❒
Varicosities	❒				
Skin	❒	Spine	❒		

Details of Abnormal Findings:

_____

_____

_____

_____

Psychological Status:

_____

_____

_____

Suggested Limitations and/or Accommodations:

_____

_____

_____

_____

_____

Is the student being treated with any medication that would impair their ability to participate in a nursing/radiography program?

_____

_____

_____

Do you consider this applicant mentally and physically able to undertake this nursing/radiography program?

_____

_____

_____

_____

Date: _____

Signature of Examining Health Care Provider: _____

Print name of Examining Health Care Provider: _____