South Central College

Nursing Program
Student Health Record

Instructions: Complete the following form. Make copies for your personal records of all immunization documentation that you are submitting. *The South Central College Nursing Program* ***will not release or copy this information once submitted.*** Please print legibly.

Name_____ SCC ID#_____
Last First MI.

Emergency Contact

Name	Phone
Relationship to student	

Physician Contact

Name	Phone
Clinic Name	

Do you have or have you ever had any of the following: (Mark all that apply)
For office information only.

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Rheumatic fever
- ☐ Abnormal blood pressure
- ☐ Ulcers
- ☐ Diabetes
- ☐ Back trouble
- ☐ Knee injury
- ☐ Hernia
- ☐ Severe headaches
- ☐ Head injury
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Fainting spells
- ☐ Jaundice
- ☐ Hepatitis (circle those that apply: A-B-C-D-E-G)
- ☐ Asthma or Hay Fever
- ☐ Tumors
- ☐ Stroke
- ☐ Bladder or Kidney Trouble
- ☐ Hearing impairment
- ☐ Excessive/ prolonged bleeding
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Chemical Dependency
- ☐ HIV
- ☐ Anemia
- ☐ Amputation of any limb
- ☐ Tuberculosis/lung disease
- ☐ Thrombophlebitis
- ☐ Cancer Type:_____

If you checked any of the above, please describe:_____
_____

Are you pregnant? NO or YES Due Date: _____

Have you ever had any other serious illnesses, hospitalizations, surgeries or accidents? NO or YES

If yes, please describe:_____

Do you have work restrictions? YES or NO (If yes, physician's signed order is required)

List any allergies:_____

List any medications:_____
_____

Date of last physical exam:_____ Are you currently under the care of a physician?_____

If yes, for what reason?_____

Immunization Records: (clinical documentation must be included for each item listed below with this form). Immunization information may be obtained from Minnesota's immunization registry database (MIIC). Immtrack is the local MIIC administrator and students can request immunization information by calling: (800) 658-2877 -or- (507) 304-4458, or from your healthcare provider/clinic.

Hepatitis B
Documentation of immunity status required.
Check those that apply.

- ☐ History of disease, Date:_____
  -OR-
- ☐ History of Hep B vaccine (3 doses),
  1st date _____
  2nd date _____
  3rd date _____
  -OR-
- ☐ Hep B vaccines in progress,
  -OR-
- ☐ Positive serological proof of Hepatitis B antibodies. Date: _____

- ☐ **Clinical documentation attached -OR- signed declination form (page 3), with dates.**

MMR (Mumps, Measles, Rubella) Documentation of immunity is required.

- ☐ Born before 1957, one vaccine on or after 1st birthday, Date:_____
  -OR-
- ☐ Born after 1957, two vaccines required after 1st birthday,
  Date:_____, Date:_____
  -OR-
- ☐ Serologic titer (including all three diseases)
  Date:_____
- ☐ **Clinical documentation attached, with date(s) received.**

Influenza Vaccine

Date of Vaccination: _____

Varicella (Chicken Pox)
Documentation of immunity is required

- ☐ Must have reliable history of disease, Date:_____
  -OR-
- ☐ History of two doses of the vaccine,
  Date:_____, Date:_____
  -OR-
- ☐ Had serologic Titer drawn. Date: _____
- ☐ **Clinical documentation attached, with date received.**

Pertussis (Tdap)
TDAP vaccine once as an adult is strongly recommended

- ☐ **TDAP vaccine date: _____**
- ☐ **Clinical Documentation attached, with date received.**

Tetanus/Diptheria (TD)
Required within last ten years. (If you need a TD shot, it is recommended that you receive the TDap.)

- ☐ *TD vaccine. Date: _____*
- ☐ **Clinical documentation attached, with date received.**

Mantoux
A 2-step mantoux is required on admission to the nursing program, and a regular 1-step for returning students. Mantoux testing is required at a minimum of every 12 months. If a Mantoux test is positive, a negative chest x-ray is required. ***Date of chest x-ray*** _____

1st step Mantoux (Tuberculin skin test or TST

- ☐ **Date Given: _____ Date Read: _____ Results: _____**

2nd step Mantoux (Tuberculin skin test or TST) Student should receive 2nd injection 1 to 3 weeks after 1st injection

- ☐ **Date Given: _____ Date Read: _____ Results: _____**

- ☐ **Clinical documentation must be attached, with read dates.**

Hepatitis B Declination

Hepatitis B vaccine series needs to be completed, in progress, ***OR*** sign the declination below:

***I understand I can refuse to be vaccinated for hepatitis B. It has been explained to me that because of the potential for occupational exposure to hazardous body fluids, I continue to be at risk of acquiring hepatitis B. Some clinical sites may not allow participation in clinical experiences at their clinical site without the hepatitis B vaccination. The nursing program does not guarantee an alternative facility placement. If no facility placement is available, you may be terminated from the Nursing Program.**

***I, individually, and on behalf of my heirs, successors, assigns and personal representatives, herby release and forever discharge the University, the Minnesota State Colleges and Universities, the State of Minnesota, and its employees, agents, officers, trustees and representatives (in their official and individual capacities) ("Releasees") from any and all liability whatsoever for any and all damages, losses or injuries (including death). I sustain to my person or property or both, including but not limited to any claims, demands, actions, causes of action, judgments, manner with my declining to be vaccinated for Hepatitis B during my nursing education at South Central College whether caused by the negligence of the Releasees or otherwise; except that which is the result of gross negligence and/or wanton misconduct by the Releasees.**

_____

Student Signature

_____

Date

Documentation for all immunizations must be submitted with this form by the documentation deadline. Make copies for your own records. SCC is will not release or copy this information once submitted. It is the student's responsibility to provide current documentation of any immunizations obtained during the course of the Nursing program.

I VERIFY THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE.

Name_____

Date_____