I give consent for PPSC Nursing Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

_____ _____
Student Signature Date

Pikes Peak State College Nursing Program Health and Immunization Record

Student Name _____
Last First Middle Phone Number

Permanent Address _____
Street Number/Name City State Zip Code

Date of Birth [ ][ ][ ] PPCC S#_____ Student Email: _____
Mo Day Yr

Part A: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. Enter all information in English.

REQUIRED FOR ALL STUDENTS

I. TETANUS, DIPHTHERIA & PERTUSSIS (Tdap)-booster must be within the last ten years [ ][ ][ ]
Mo Day Yr

II. MMR (Measles, Mumps, Rubella)
Two doses required, at least one month apart… Dose #1 [ ][ ][ ] Dose #2 [ ][ ][ ]
Mo Day Yr Mo Day Yr

Students in postsecondary education institutions, international travelers, and household or close personal contact of immunocompromised persons with no evidence of immunity to measles, mumps or rubella: 1 dose MMR if previously received 1 dose MMR, or 2-dose series MMR at least 4 weeks apart if previously did not receive any MMR. **-CDC, 2019**

OR ALL 3 OF THE FOLLOWING CRITERIA ARE MET:

MEASLES (RUBEOLA)
Has report of positive immune **titer**. **Specify date**: [ ][ ][ ] Value of Titer: _____
Mo Day Yr

Or **two doses** of individual rubeola vaccine: Dose #1 [ ][ ][ ] Dose #2 [ ][ ][ ]
Mo Day Yr Mo Day Yr

RUBELLA (GERMAN MEASLES)
Has report of positive immune **titer**. **Specify date**: [ ][ ][ ] Value of Titer: _____

Or **two doses** of individual rubella vaccine: Dose #1 [ ][ ][ ] Dose #2 [ ][ ][ ]
Mo Day Yr Mo Day Yr

MUMPS
Has report of positive immune **titer**. **Specify date:** [ ][ ][ ] Value of Titer: _____

Or **two doses** of individual mumps vaccine: Dose #1 [ ][ ][ ] Dose #2 [ ][ ][ ]
Mo Day Yr Mo Day Yr

Healthcare personnel born in 1957 or later with no evidence of immunity to measles, mumps or rubella: 2-dose series MMR at least 4 weeks apart for measles or mumps, or at least 1 dose MMR for rubella; if born before 1957, consider 2-dose series MMR at least 4 weeks apart for measles or mumps, or 1 dose MMR for rubella

CONTINUE on to Part B for Hepatitis B, Varicella, Tuberculosis Screening (Required for all students)

I give consent for PPSC Nursing Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

_____ _____
Student Signature Date

PART B: Hepatitis B, Varicella, Tuberculosis Screening

III. HEPATITIS B:

Has report of positive immune **titer**. **Specify date:** ☐☐☐ (Mo Day Yr) Value of Titer: _____

Or **three doses** of individual hepatitis vaccine:

Dose #1 ☐☐☐ (Mo Day Yr) Dose # 2 ☐☐☐ (Mo Day Yr) Dose #3 ☐☐☐ (Mo Day Yr)

IV. VARICELLA: (chicken pox): Two doses one month apart recommended for adults with no history of disease:

Has report of positive immune **titer**. **Specify date**: ☐☐☐ (Mo Day Yr) Value of Titer: _____
(*History of disease cannot be accepted*)

Or **two doses** of individual varicella vaccine: Dose #1 ☐☐☐ (Mo Day Yr) Dose #2 ☐☐☐ (Mo Day Yr)

V. TUBERCULOSIS:

1. Does the student have signs or symptoms of active TB disease? ☐ YES ☐ NO

If NO, proceed to 2.

If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY (Based on assessment criteria outlined above)

2.A. Tuberculin Skin Test/PPD:

Date given: ☐☐☐ (Mo Day Yr) Date read: ☐☐☐ (Mo Day Yr) Results:_____MM
(Record actual MM of indurations, transverse diameter; if no in duration, write "0")

Interpretation (based on MM of indurations as well as risk factors)

☐ Positive ☐ Negative

B. Chest X-Ray: (required if tuberculin skin test is positive or if PPD has not been placed but patient is at risk of disease; must have been performed. *Must be within 5 years.

Result: ☐ Normal ☐ Abnormal Date of chest x-ray: _____

INH Initiated ☐ ☐ Date_____X_____months

C. Quantiferon: Date of Test:_____ ☐ Positive (≥ 0.35 IU/mL) ☐ Negative

History of positive PPD and/or negative Quantiferon results requires annual TB screening with a Healthcare Provider:

1. Have you been having a bad cough that last longer than 2 weeks? ☐ YES ☐ NO
2. Have you been having pain in the chest? ☐ YES ☐ NO
3. Have you been coughing up blood or sputum (phlegm from deep inside the lungs)? ☐ YES ☐ NO
4. Have you experienced weakness or fatigue? ☐ YES ☐ NO
5. Have you experienced chills, fevers, or sweating at night? ☐ YES ☐ NO
6. Have you experienced weight loss or a loss of appetite? ☐ YES ☐ NO

CONTINUE on to Part C for Influenza Vaccine (Required for all students)

I give consent for PPSC Nursing Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

_____ _____
Student Signature Date

PART C. Influenza – During Current Flu Season

VI. INFLUENZA:

Date of last dose: | | | | (Mo Day Yr) Lot #_____ Location given: _____

VII. COVID:

Dose 1 Date: | | | | (Mo Day Yr) Manufacturer: _____

Dose 2 Date: | | | | (Mo Day Yr) Manufacturer: _____

Booster Date: | | | | (Mo Day Yr) Manufacturer: _____

HEALTH CARE PROVIDER: (signature required as validation of correct information for immunizations and TB assessment)

Printed Name:_____

Signature:_____

Date:_____

Address: _____
Street Number/Name

_____
City State Zip Code

Phone: _____

CONTINUE on to Part D for Physician Statement (Required for all students)

I give consent for PPSC Nursing Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

_____ _____
Student Signature Date

PART D. Physician Statement

PLEASE PRINT: complete this form entirely—leave no question unanswered. If a question does not apply to patient, please answer "N/A" on that line.

Student Name:_____DOB: _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN OR PRIMARY CARE PROVIDER:

Height: _____ Weight: _____ Pulse: _____

Blood Pressure:_____ Resp: _____

Vision (Snellen): / R/L Corrected: Glasses ☐ Contacts ☐

Hearing R:_____L: _

Check line if normal:		**Within Normal Limits**	**Abnormal**
_____	General Appearance	☐	☐
_____	Head & Scalp	☐	☐
_____	Face	☐	☐
____	Skin	☐	☐
____	E.E.N.T.	☐	☐
____	Neck	☐	☐
____	Heart	☐	☐
____	Lungs	☐	☐
____	Breasts	☐	☐
____	Abdomen	☐	☐
____	Back & Spine	☐	☐
____	Extremities	☐	☐
____	Lymphatics	☐	☐
____	Neurological	☐	☐
____	Genitourinary	☐	☐

***Is general health adequate to allow participation in a nursing education program and to perform essential duties of an RN working in a hospital, including CPR, administration of IV medication, opening of obstructed airways, catheterization, safe patient transfer/lifting, and other motor skills? YES NO _____**

Physician Statement continued on next page (Required for all students)

I give consent for PPCC Nursing Program to share the results of the immunizations and physical questionnaire with clinical agencies as requested

_____ _____
Student Signature Date

Student Name:_____ **DOB:** _____

Physician Statement - Continued

Past illnesses: _____

_____

Injuries: _____

_____

Hospitalizations: _____

_____

Personal Medical History: (Please circle all that apply)

ADHD	Headaches	High Blood Pressure	Parkinson's disease
Alcoholism	Crohn's Disease	Kidney Stones	Peripheral Vascular Disease
Allergies, Seasonal	COPD/Emphysema	Kidney Disease	Peptic Ulcer
Anemia	Dementia	High Cholesterol	Psoriasis
Anxiety	Depression	HIV	Pulmonary Embolism (PE)
Arrhythmia (irregular heart	Diabetes: 1 or 2	Hepatitis	Rheumatoid Arthritis
beat)	Diverticulitis	Irritable Bowel Syndrome	Seizure Disorder
Arthritis	DVT (Blood Clot)	Lupus	Sleep Apnea
Asthma	GERD (Acid Reflux)	Liver Disease	Stroke
Bladder	Glaucoma	Macular Degeneration	Thyroid Disorder
Problems/Incontinence	Heart Disease	Mental Disorder	Ulcerative Colitis
Bleeding Problems	Heart Attack (MI)	Neuropathy	
Cancer: _____	Hiatal Hernia	Osteopenia/Osteoporosis	

Allergies to medications: _____

_____

Allergies to other substances: _____

_____

Medications student is presently taking: _____

_____

Present or chronic medical problems : _____

_____

Health Care Provider Signature:_____ Date: _____