AURORA UNIVERSITY and GEORGE WILLIAMS COLLEGE of AURORA UNIVERSITY
School of Nursing

Certificate of Health Examination and Immunity

Student to complete pages 1-3

Name:_____ **Date of Birth:**____/____/____ **Sex:** ❒ M ❒ F **SS#:**_____
(Last / First / Middle) Month / Day / Year

Permanent Address: _____ **Phone Number:** _____
(Street/Apartment Number)

_____ **Country:**_____
(City / State / ZIP)

Do you plan to live on campus? ❒ Yes ❒ No **Campus Phone Number:**_____

Parent/Guardian: _____ _____ _____ _____
(Name) (Relationship) (Home Phone) (Work Phone)

_____ _____ _____ _____
(Name) (Relationship) (Home Phone) (Work Phone)

In case of emergency, notify: _____

Semester and year of enrollment: ❒ Fall____ ❒ Spring ____ ❒ Summer ____

Class Standing: FR / SO / JR / SR / 5th / Graduate Student _____ (year) **Will you be attending:** ❒ Full-time ❒ Part-time

Have you previously attended Aurora University or George Williams College? ❒ No ❒ Yes - If yes, please indicate year(s)_____

Are you an AU athlete? ❒ No ❒ Yes – If yes, **please indicate which sport(s):** _____

Have you had:

	NO	YES		NO	YES		NO	YES
Allergies (seasonal)			Unusual weakness			Rheumatic fever		
Head injury			Numbness/Tingling			High blood pressure		
Dizziness/fainting			Gastrointestinal problems			Low blood pressure		
Dizziness/fainting with exertion			Loss of paired organ function			Heat related illness (exhaustion/stroke)		
Headaches (migraines)			Recent weight changes			Hernia		
Seizures/Epilepsy			Gallbladder problems			Kidney/urinary problems		
Meningitis			Stomach ulcers			Anemia		
Ear problems (hearing loss)			Diabetes Mellitus (Type I/II)			Blood disorders		
Hearing aid			Low blood sugar			Chicken pox		
Eye problems			Lymph gland swelling			Cancer		
Wear glasses/Near or Far sighted			Lupus			Counseling/mental health treatment		
Wear contact lenses			Organ transplant			Marfan's Syndrome		
Sinus problems			Liver disease			Eating disorders		
Strep throat (recurrent)			Hepatitis A, B, C			Skin problems		
Thyroid problems			Mononucleosis			Arthritis		
Frequent colds			Heart murmur			Fibromyalgia		
Asthma (chronic)			Heart arrhythmia			Muscular Dystrophy		
Asthma (exercise induced)			Heart disease			Paralysis		
Coughed up blood			Heart Attack			Anxiety/Panic attacks		
Cough > 2weeks long			Night sweats			Depression		
Respiratory problems			Parkinson's disease			Alcohol/Substance abuse		
Polio			Multiple Sclerosis			Back problems		
Positive TB Skin Test *Date of chest x-ray* _____ INH treatment? Yes or No		Year if yes	Bacille Calmette-Guerin Vaccine		Date	Need to use a mobility aid (i.e. walker, cane, wheelchair, scooter, etc.)		

Student's Name: _____ **Date of Birth:** _____ **Page 2**

Health History: Please answer all of the following questions.

Orthopedic Injuries: (Including fractures, dislocations, deformities, swelling, tendonitis, bursitis, or joints that lock or "give out") *					
	NO	**YES**		**NO**	**YES**
Ankle		R L	Elbow/arm		R L
Shin Splints		R L	Wrist/hand		R L
Knee		R L	Neck		R L
Hip		R L	Head		
Back			Concussion/loss of consciousness		
Shoulder		R L	Internal		

Please explain all answers marked with *YES:

_____

1. **Do you have any allergies?** ***(Medications, foods, environmental, insect bites/stings):*** ❒ No ❒ Yes (explain below)

Allergen	**Reaction**

2. **Are you currently under the supervision of a physician?** ❒ No ❒ Yes (please explain below)
   If yes, please explain: _____
   _____
   _____

3. **Are you currently taking any medications?** ❒ No ❒ Yes (please list below)
   Please include medications taken on a regular or as-needed basis along with any vitamins, herbal or nutritional supplements.

Medication (name, dose, frequency)*	**Reason**
**If you administer injectable prescription medications, contact the Wellness Center to receive information on disposal of syringes and needles.*	

4. **Have you ever been hospitalized (injury or illness) or had any surgical procedures?** ❒ No ❒ Yes (please list below)

Reason	**Dates**

5. **Have you ever been diagnosed with a stress fracture?** ❒ No ❒ Yes (please provide details below)

Location	**Date**

6. **Do you have a family history of the following?**

Disease	**No**	**Yes**	**If yes, please indicate relationship**
Diabetes			
Cancer			
Heart disease			
Hypertension			
Tuberculosis			
Stroke			

****Has any member of your family died suddenly before the age of 40 from a non-traumatic cause?***
❒ No ❒ Yes - If yes, please explain how: _____

7. **Please complete the appropriate section:**

For Women	**For Men**
Onset first menstrual period (age):	Testicular conditions ❒ No ❒ Yes **Explain:**
Abnormal flow? ❒ No ❒ Yes **Explain:**	
Excessive/severe cramping? ❒ No ❒ Yes	Prostate conditions ❒ No ❒ Yes **Explain:**
Pregnant now or within past year? ❒ No ❒ Yes	
Date of last pelvic exam**:**	

8. **Have you traveled outside the United States for longer than a month?** ❒ No ❒ Yes (when and where)

Country	**When**

9. **Have you ever had an injury to the eye involving metallic fragments, an implanted devise placed (i.e. aneurysm clips, cochlear implants, pacemaker, spinal cord stimulator, etc.), an injury by a metallic object (i.e. bullet, BB, Shrapnel, etc.), or any other implanted metallic object?** ❒ No ❒ Yes (please comment)

_____

_____

_____

10. **Do you have any permanent physical, mental, or learning disabilities?** ❒ No ❒ Yes (If yes, what are they?)

_____

_____

_____

11. **Do you have any physical, mental, or learning limitations which will require accommodation in order to allow you to perform the job duties?** ❒ No ❒ Yes (please describe any accommodation you are requesting)

_____

_____

_____

12. **Is there anything we should know about your health that we have not asked yet?** ❒ No ❒ Yes
If yes, please explain: _____

I HEREBY CERTIFY THAT <u>ALL</u> QUESTIONS ON <u>PAGES 1, 2, AND 3</u> ARE ANSWERED TO THE BEST OF MY KNOWLEDGE.

Student Signature: _____ Date: _____

******A NP/MD/PA signature is required for the physical examination and immunization history sections. ******

Physical Examination: To be completed by a primary care provider (nurse practitioner, physician, or physician's assistant)

TO THE EXAMINING PHYSICIAN: Please review the student's history, complete the physical examination and immunization history and comment on all positive answers (also complete and sign page 5).

Required Measurements				**Strongly Recommended Tests**	
Height	**Weight**	**B/P**	**Pulse**	**Urinalysis (dipstick)** Alb._____ Sug._____	**Hemoglobin or Hematocrit** _____ gms/% _____%

Clinical Evaluation:	**Normal**	**Abnormal**	**Comments**
Skin			
Eyes, ears, nose, sinuses			
Mouth/dental			
Throat			
Heart (murmurs, size, sounds)			
Respiratory system			
Gastrointestinal system			
Genital-urinary system			
Neurological status			
Musculoskeletal system			
Spinal examination			
Nutritional status ***Please list any dietary restrictions***			
Mental health			
Other *(general comments)*			

Orthopedic Exam: ❒Normal ❒ Abnormal
(Please explain all abnormalities or orthopedic concerns)

HEALTHCARE PRACTITIONER STATEMENT

❒ **This patient is free of clinically apparent communicable disease and current with his/her immunizations.**

As a student, this person will be assigned to provide direct patient care including patient transfers. This student may provide patient care:

❒ **Without restrictions** ❒ **With the following restrictions: _____**

_____

❒ **May not participate in clinical experience at this time.**

Primary Care Provider Verification of Physical Exam (Required):

NP/MD/PA:_____ Date of Exam:_____

Address:_____

Phone Number (with area code) :_____Signature:_____

Office Stamp:

Immunization History: To be completed by primary care provider

Required Immunizations
*** The following immunizations are required. ***

Majors require additional immunizations:
Nursing majors: Two-Step Tuberculosis Skin Testing and Results (after 1 year 1 step required), and proof of immunity to Measles, Rubella, Mumps, Varicella, and Hepatitis B

MEASLES (Rubeola, Hard, Red, 10 day)

❒ Lab test proving immunity _____/_____/_____ **Attach lab report**
❒ If not immune repeat series _____/_____/_____ _____/_____/_____
month / day / year month / day / year

RUBELLA (German measles, 3 day)

❒ Lab test proving immunity _____/_____/_____ **Attach lab report**
❒ If not immune repeat series _____/_____/_____ _____/_____/_____
month / day / year month / day / year

MUMPS

❒ Lab test proving immunity _____/_____/_____ **Attach lab report**
❒ If not immune repeat series _____/_____/_____ _____/_____/_____
month / day / year month / day / year

VARICELLA (Requirements can be met by one of the following):

❒ Lab test proving immunity _____/_____/_____ **Attach lab report**
❒ If not immune repeat series _____/_____/_____ _____/_____/_____
month / day / year month / day / year

HEPATITIS B:

❒ Lab test proving immunity _____/_____/_____ **Attach lab report**
❒ If not immune repeat series (3 doses of vaccine**):**

1st: _____/_____/_____ **2nd:** _____/_____/_____ **3rd:** _____/_____/_____
month / day / year month / day / year month / day / year

INFLUENZA: ***Due by October 1st.***

_____/_____/_____
Month / day / year

MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135):
If initial dose given at age 13-15 yrs.: booster dose at 16-18 yrs. of age is recommended.

❒ Conjugate (MCV4): _____/_____/_____ (Preferred)

OR

❒ Polysaccharide (MPSV4): _____/_____/_____

HEPATITIS A (OPTIONAL):

_____/_____/_____ _____/_____/_____
month / day / year month / day / year

POLIO (OPTIONAL):

_____/_____/_____ _____/_____/_____
month / day / year month / day / year

DIPHTHERIA, PERTUSSIS, TETANUS (Tdap) or TETANUS/DIPTHERIA (Td)

#1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____ #4_____/_____/_____
month / day / year month / day / year month / day / year month / day / year

Latest Booster: ***(must be within past 10 years)***
_____/_____/_____
month / day / year

❒ Tdap required

TUBERCULOSIS TEST (PPD/Mantoux or IGRA — please specify test):
If positive, Chest X-ray required; Date _____/_____/_____ **Chest X-ray results:** Normal / Abnormal

PPD one-step given on _____/_____/_____, read on _____/_____/_____ **Results:** Negative / Positive **Signature:** _____

PPD two-step given on _____/_____/_____, read on _____/_____/_____ **Results:** Negative / Positive **Signature:**_____

Provider Verification of Immunization History (Required):

NP/MD/PA Name:_____ Phone number:_____

Address:_____

Signature:_____ Date:_____

Office Stamp: