COMPREHENSIVE CLINICAL HEALTH FORM
ROCHESTER UNIVERSITY SCHOOL OF NURSING

TO BE COMPLETED BY STUDENT (PLEASE PRINT)

Name (Last, First, M.I.) ____

Birth Date:_______________ Gender: ____ Female ____ Male RC ID #_______________ RC email:________________

Are you being treated for any disease, disability or condition?		Yes (Please explain)		No

Current Medications:	**Current Allergies:**

*This record will become part of the student's School of Nursing file and disclosed to school officials with a legitimate interest.

I hereby represent that each answer to a question herein and all other information otherwise furnished is true and correct. I further represent that such answers and information constitute a full and complete disclosure of my knowledge with respect to the question or subject to which the answer or information relates. I understand that any incorrect or false statements or information furnished by me will subject me to disqualification from the Rochester University School of Nursing at any time.

Authorization to release this medical record to Rochester University School of Nursing

Student Signature ____ Date_________

TO BE COMPLETED BY HEALTH CARE PROVIDER

NAME OF STUDENT:_____________________________________

Height:_____________ Weight:____________ Blood pressure:_________/_________ Pulse:____________

Distance vision: right 20/______ corr. to 20/_______ left 20/________ corr. to 20/________

Examining Health Care Provider: ________________________ **Examining Health Care Provider:**____________________________________
Please Print **(Signature Required)**

Address:_______________________________________ City:______________________ State:______ Zip:__________ Phone:_______________

Normal	Abnormal	Check each item in appropriate column. Enter **NE** if not evaluated.	Normal	Abnormal	Check each item in appropriate column. Enter **NE** if not evaluated.
		SKULL, SCALP, FACE, NECK, THYROID			ANUS and RECTUM (OPTIONAL) (Prostate, if indicated)
		NOSE and SINUSES			ENDOCRINE SYSTEM
		MOUTH (tongue, gingivae, teeth)			G.U.SYSTEM (OPTIONAL) (Pap test-optional)
		THROAT and TONSILS			UPPER EXTREMITIES
		EARS (Int. and Ext. Canals)			FEET (lateral pain, infection)
		EYES (Pupils, E.O.M. conjunct.)			LOWER EXTREMITIES
		LUNGS and CHEST (include breasts)			SKIN, OTHER MUSCULOSKELETAL
		HEART (rhythm, sounds, murmurs)			LYMPHATIC GLANDS
		ABDOMEN and VISCERA (include hernia)			NEUROLOGIC

This section must be completed by Health Care provider

Physical examination date:___________________ (Attach health assessment form)

TB Test date: ___________ _____**mm** **If positive:**
(*completion needed for all students)* **Chest X-ray date (within last 5 years): __________ Pos/Neg (*circle one*)**

Tetanus (tdap) date: __________________

Rubella Titer date:____________________ immune/not immune (circle one)

Rubeola Titer date:___________________ immune/not immune (circle one)

Mumps Titer date:____________________ immune/not immune (circle one)

Or MMR Vaccination 1st date:__________ MMR Vaccination 2nd date:____________

Varicella Titer date: immune/not immune (circle one)___________ ***Or*** Varicella Vaccination date:_____________

Hepatitis Titer date: immune/not immune (circle one)___________
Or Hepatitis B Vaccination 1:___________

Hepatitis B Vaccination 2:___________

Hepatitis B Vaccination 3:___________

Or Hepatitis B Acknowledgment and Release Form (Signed):__________

Health Care Provider Signature:____ Date:____________

This section should be completed and submitted ONLY in the case of a student choosing not to acquire the Hepatitis B vaccinations.

HEPATITIS B VACCINE ACKNOWLEDGMENT AND RELEASE
ROCHESTER UNIVERSITY
SCHOOL OF NURSING STUDENTS

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I have declined the hepatitis B vaccination at this time. I agree to release, exonerate and forever unconditionally discharge and hold harmless Rochester University, its Board of Trustees, officers, directors, employees, representatives, agents and assigns and the facility where I receive my clinical training, from any and all liability, claims or causes, known or unknown, now or hereafter arising directly or indirectly out of or relating in any way to my declining the Hepatitis B vaccinations. I acknowledge that I am placing myself and others at risk of serious illness should I contract a disease that could have been prevented through proper vaccination.

Student Name: ____
(Please Print)

Student Signature: ____ Date: __________________