Purdue University School of Nursing
West Lafayette Campus
Sophomore Student Health Record
Upload to your CastleBranch myCB account

Last Name First Middle Gender Birth Date (dd/mm/yyyyy)

Home Address City State Zip Code

Do you now have or have you ever had:

	No	Yes		No	Yes
Allergies/Asthma			Gastrointestinal Disorder		
Behavior Disorder			Hepatitis/Jaundice/Gallbladder		
Cancer			High Blood Pressure		
Cardiovascular Disease			Kidney/Urinary Disorder		
Diabetes			Musculoskeletal Disorder		
Drug/Alcohol Abuse			Psychiatric/Mental Health Disorder		
Eye/Ear/Nose/Throat Disorder			Pulmonary/Lung Disease		
Endocrine Disorder			Skin Problems/Disease		
Epilepsy/Seizures			Other		

If answer is yes, please elaborate on details:

Surgeries (with dates):

Previous hospitalizations (with dates):

Current medications:

I attest that the information shown above is true and accurate to the best of my knowledge and that I am in general good health.

Student's Signature:

Printed Name: Date:

TO BE FILLED OUT BY A LICENSED HEALTH PROFESSIONAL (MD, DO, NP) Based upon a physical exam done within the past six months.

Height: _____ Weight: _____ BP: _____ Pulse: _____ RR: _____

Vision: OD___ OS ___ OU ___ With correction: Color Vision: ___ Normal Hearing: ___ Normal
OD ___ OS ___ OU ___ Without correction: ___ Colorblind ___ Abnormal*

* Provide audiology report with audiogram results and any adaptations

	Normal	Abnormal	Comments/Elaboration
Head and Neck (HEENT)			
Lungs/Respiratory			
Heart			
Abdomen			
GU			
Musculoskeletal			
Neurologic			
Metabolic/Endocrine			
Vascular			
Skin, Hair, Nails			
Is the patient now under treatment for: a) Serious medical condition? b) Serious emotional condition?			
Are you the patient's regular physician/NP?			

Summary of Significant Abnormalities: _____

_____

_____

Recommendations for student related to these findings: _____

_____

_____

_____

Do you know of any physical or emotional reason why this student would not be able to withstand the rigors of nursing school education including late and early hours, heavy lifting, standing for long periods, fine and gross sensory/motor skills?

___ No ___ Yes Please elaborate on yes responses: _____

_____

_____

Physician/NP Name (printed): _____Phone (___) ____-_____ Fax (___) ____-_____

Address:_____
Street City Zip

Physician/NP Signature: _____ Date: _____

Name:______________________________

IMMUNIZATION RECORD

Required Immunizations

PPD - also known as Mantoux Tuberculin Skin Test (TST) Only one step test needed this year. **Cannot be administered before May 1.** - **If positive, chest X-ray or Interferon Gamma Release Assay Blood Test required with appropriate follow-up**	Upload verified test results from healthcare provider: PPD **indicating mm reading** or X-ray results or Assay results.
Influenza (annual – within 30 days of when vaccine becomes available in the fall	**Upload verified proof of vaccine from healthcare provider when new vaccine is available in the fall.**

Required and recommended vaccinations may be modified annually based on the Centers for Disease Control and Prevention recommendations and clinical agency requirement.