Purdue University School of Nursing
West Lafayette Campus
2nd Degree Student Health Record **Upload**
to your Complio account by August 1

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

Read each immunization requirement carefully. As a nursing student, many of the required immunizations are more extensive than those required by the university of the general student body. All vaccinations and required serological evidence of immunity listed below must be completed. Nothing may be left blank.

Required Immunizations

Measles (Rubeola), Mumps and Rubella (MMR) Must have 2 doses at least 4 weeks apart - OR Born prior to 1957 and one dose of MMR - Or Serological evidence of immunity, date of positive titer	**Upload verification from healthcare provider with date(s)**
Varicella (chickenpox) Must have 2 doses at least 28 days apart - Or Serological evidence of immunity, date of positive titer **Date of disease is NOT sufficient – must have vaccination or positive titer**	**Upload verification of vaccine dates or titer results from healthcare provider.** **Date of disease is NOT sufficient – must have vaccination or positive titer**
Tetanus/Diphtheria/Acellular Pertusis (Tdap) Must have been vaccinated within the past 10 years.	**Upload verification from healthcare provider with date(s)**
Polio (Series of three plus booster; oral or injectable)	**Upload verification from healthcare provider with date(s)**
Hepatitis B Serologic evidence of immunity in the form of a **positive Hepatitis B Surface Antibody titer** at least 1-2 months after final vaccine dose. If titer is negative, consult with PUSON Student Services.	**Upload verified POSITIVE titer results from healthcare provider**
TB **Two-step tuberculosis skin test (baseline PPD followed 1 – 3 weeks later by 2nd PPD which is then "read" to identify mm of induration)** **OR** **QuantiFeron Gold Blood Test** - **If positive, chest X-ray or Interferon Gamma Release Assay Blood Test required with appropriate follow-up**	Upload verified test results from healthcare provider: Two PPD tests 1 – 3 weeks apart **indicating mm reading** or X-ray results or Quantiferon Gold blood test 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.**
Recommended, not Required Immunizations	
Meningococcal	**Attach verification from healthcare provider with date(s)**
Hepatitis A	**Attach verification from healthcare provider with date(s)**

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