Eastern International College

Dear Student:

Please complete the form and return to the Nursing Department.

_____ Male_____ Female_____
Last Name First Name MI.

Street Address **City** **State** **Zip Code**

_____ _____ _____
Apt. No. Telephone No. Entry Date

_____ _____ _____
Date of Birth Place of Birth Student ID#

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

_____ _____
Name Relationship

Street Address **City** **State** **Zip Code**

_____ _____
Telephone No. (Home) **Telephone No. (Work)**

PERSONAL HISTORY – Please answer all questions. – Changes in your medical history, including pregnancy must be reported to Nursing office.

DISABILITY – A disability is a medical problem that causes long term impairment of your ability to work or function.

Do you have a medical disability? YES _____ NO _____

If 'YES', please specify_____

MEDICATIONS – Do you take any medicine frequently or regularly? YES _____ NO _____

If "YES", list those medications_____

ALLERGIES – An allergy is a skin rash, hives, joint pain, swelling or fever after exposure to a certain food, medication, insect, pollen, or other substance.

Do you have any allergies? YES _____ NO _____

If "YES", please specify_____

Please check if you ***have/had*** any of the following:

_____ Albumin/Sugar in Urine	_____ Disease/Injury to Joints	_____ Heart Problems/Murmur
_____ Anemia	_____ Dizziness/Fainting	_____ High/Low Blood Pressure
_____ Asthma	_____ Ear/Nose/Throat Problems	_____ Kidney Problems
_____ Back Problems	_____ Epilepsy/Convulsions	_____ Malaria
_____ Cancer/Tumor/Cyst	_____ Eye Problems	_____ Pain/Pressure in Chest

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HEALTH CLEARANCE FORM – to be completed by Health Care Provider

Name:_____

Instructions: This form must be completed by the Health Care Provider in addition to the EIC Student Health Record. Submit this document to the Nursing Department once all items are completed.

TUBERCULIN SCREENING – (PPD 2-Step OR Chest X-ray within 3 months of start of program will be accepted)

PPD STEP 1: Date given: ____/____/____ Date Read: ____/____/____ Results: _____mm

PPD STEP 2: Date given: ____/____/____ Date Read: ____/____/____ Results: _____mm
(2nd Step is done 1 to 12 weeks after Step 1)

OR:

CHEST X-RAY – Required if known positive Mantoux/PPD reactor. Within 3 months of start of program will be accepted. Please attach result.

TITERS – Quantitative Titers Required - Must have blood work completed and titer results printed

Measles: ☐ Immune (attach results) ☐ Not immune / equivocal result (requires booster and follow up titers in 6 weeks)

Mumps: ☐ Immune (attach results) ☐ Not immune / equivocal result (requires booster and follow up titers in 6 weeks)

Rubella: ☐ Immune (attach results) ☐ Not immune / equivocal result (requires booster and follow up titers in 6 weeks)

Varicella: ☐ Immune (attach results) ☐ Not immune / equivocal result (requires booster and follow up titers in 6 weeks)

Hepatitis B: ☐ Immune (attach results) ☐ Not immune (proof of 3 step series vaccine)

Note: Equivocal results are not acceptable. Revaccination required if results equivocal. Students requiring revaccination will require follow-up titers.

VACCINATIONS

HEPATITIS B #1: Date given: ____/____/____ HEPATITIS B #2: Date given: ____/____/____

HEPATITIS B #3: Date given: ____/____/____ Tdap: Date given: ____/____/____

MMR IMMUNIZATION: Dates must be included. First dose Measles: ____/____/____ Second dose Measles: ____/____/____

One dose Mumps: ____/____/____ One dose Rubella: ____/____/____

OR

First dose MMR: ____/____/____ Second dose MMR: ____/____/____

INFLUENZA (FLU) VACCINE: Flu season Aug. 15 to Mar. 31 – Must provide proof of vaccine during current flu season.
Date given: ____/____/____

I certify the above individual is in good health, has no limits on physical activity and is free of contagious diseases.

_____ _____
HEALTH CARE PROVIDER'S SIGNATURE DATE

HEALTH CARE PROVIDER'S NAME_____

ADDRESS_____

_____

Please Print/Use Office Stamp

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PHYSICAL FORM – to be completed by Health Care Provider

NAME_____

ADDRESS_____

GENERAL: Date of Birth____/____/____ Height_____ Weight_____

VITAL SIGNS: B/P_____ Pulse: _____

PHYSICAL EXAMINATION

Skin:_____

Head & Neck:_____

E.E.N.T.:_____

Chest:_____

Heart:_____

Lungs:_____

Abdomen:_____

Genitourinary:_____

Musculoskeletal:_____

Neurological:_____

Glasses:_____ Contact Lenses:_____

Dentures:_____ Yes _____No

Upper_____ Lower_____ Bridge_____

Current List of Medications (name, dose, indication)

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_____ Chicken Pox	_____ Frequent Urination	_____ Palpitations
_____ Chronic Cough	_____ Gallbladder/Ulcer Problems	_____ Recent Gain/Loss of Weight
_____ Depression	_____ Head Injury with Unconsciousness	_____ Shortness of Breath
_____ Diabetes	_____ Headaches-Migraine/Frequent	

SURGERY – Please indicate

Appendectomy _____ Tonsillectomy _____ Hernia Repair _____ Other _____

FEELINGS **– Mark the frequency with which you have the feelings or problems listed by placing a check mark in the appropriate column.** ***M-MOST OF THE TIME S-SOME OF THE TIME N-NEVER***

M	S	N		M	S	N	
___	___	___	Feel sad, depressed?	___	___	___	Feel lonely?
___	___	___	Cry without apparent reason	___	___	___	Wish to end it all?
___	___	___	Plan a way to kill self?	___	___	___	Still tired after a night's sleep
___	___	___	Feel tense and anxious	___	___	___	Worry about health?
___	___	___	Worry about things generally?	___	___	___	Have Trouble falling asleep?
___	___	___	Have frightening, recurring thoughts?	___	___	___	Suffer from nervous exhaustion?
___	___	___	Get upset easily, highly irritable?	___	___	___	Get along with people?
___	___	___	Feel overly shy, sensitive?	___	___	___	Do things impulsively?
___	___	___	Greatly upset by criticism?	___	___	___	Feel optimistic about the future?
___	___	___	Feel someone is out to get you?	___	___	___	Hear voices when no one is around?

Please note you must report any change in your medical history, including pregnancy, to the Nursing office in a timely manner.