College of Health and Human Services

Governors State University   **SUCCESS BY DEGREES**

GOVERNORS STATE UNIVERSITY
College of Health and Human Services

<u>Nursing Program Student Health Form</u>

This form is to be completed by a licensed health care provider (physician or nurse practitioner) and returned to the nursing program office prior to the first course in the nursing curriculum. Failure to return this form will result in an inability to begin course work.

_____   _____   _____

Last Name   First Name   MI

_____   _____

Date of Birth   GSU Student Identification Number

Dear Health Care Provider:

The above-named student will soon be involved in clinical duties, which may expose him/her to potentially harmful infectious diseases. To assure that the student is adequately protected from harm, the following immunizations and tests should be administered and recorded. Please complete the following information and return it to the student. [***Note: A copy of the original lab report must accompany antibody titers***.]

Measles (Rubeola)   Titer/Date _____/_____
                                                      or
                                  Vaccine Administration Date_____

Rubella   Titer/Date _____/_____
                            or
                  Vaccine Administration Date_____

Mumps   Titer/Date _____/_____
                            or
                  Vaccine Administration Date_____

Varicella   Titer/Date _____/_____
                            or
                  Vaccine Administration Date_____

Tetanus   Date of Last Tetanus Booster _____

PPD Tuberculosis Skin Test

An initial 2-step TB skin test is required, with a 1-step TB skin test required annually.

Directions: The first step requires the student to receive a Mantoux Intradermal skin test, which is to be read within 72 hours. If negative, the second test is to be given 1-3 weeks later, and read within 72 hours.

Step 1
Date Given _____ Date Read_____ ❑ neg ❑ pos

Step 2
Date Given _____ Date Read_____ ❑ neg ❑ pos

Chest X-ray (if indicated) Date Given _____ Result_____
(attach copy of x-ray report)

Hepatitis B Vaccine

Dates of 3 injections: #1_____, #2_____, and #3_____
or
Date/Results of Serology* _____/_____
(*either HbsAb or HbcAb)

Physical Limitations ❑ No ❑ Yes Explain:_____
_____
_____
_____

Do you know of any disability, which would necessitate special assistance for the applicant to engage in clinical nursing behaviors? ❑ No ❑ Yes
Explain:_____
_____
_____

_____   _____   _____
Provider Signature (MD or Nurse Practitioner)   Print Name & Credentials   Date

_____   _(___)_____
Provider Address   Telephone

I, _____hereby give my permission to the above-named provider to provide the
(Student Name)
requested health information to Governors State University nursing program.

_____   _____
Student Signature   Date