VERA Z. DWYER COLLEGE OF HEALTH SCIENCES

INDIANA UNIVERSITY SOUTH BEND

Student: Please complete this section of the form and take to Physician or practitioner.

Name: (First, Middle Initial, Last) _____

University ID#: _____ Date of Birth (MM/DD/YYYY): _____

Sex/Gender: _____ Transgender (if applicable): M-F F-M

Address: _____ Apt. /Suite: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Personal History								
	Yes	No		Yes	No		Yes	No
ADHD	☐	☐	Hay Fever	☐	☐	Rheumatic Fever	☐	☐
Allergies	☐	☐	Hearing Problems	☐	☐	Unexplained Shortness of Breath	☐	☐
Anemia	☐	☐	Heart Trouble	☐	☐	Seizures	☐	☐
Anxiety	☐	☐	Heat Intolerance	☐	☐	Skin Disease	☐	☐
Arthritis	☐	☐	Hepatitis	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐
Back Injury/Disease	☐	☐	Histoplasmosis	☐	☐	Tumor/Cancer	☐	☐
Bleeding Tendency	☐	☐	Jaundice	☐	☐	Other	☐	☐
Chest Pain	☐	☐	Kidney Disease	☐	☐			
Chronic Pain Condition	☐	☐	Liver Disease	☐	☐			
Congenital Defects	☐	☐	Lung Disease	☐	☐			
Depression	☐	☐	Measles	☐	☐			
Diabetes	☐	☐	Migraine	☐	☐			
Eczema	☐	☐	Mumps	☐	☐			
Emphysema	☐	☐	Muscle Disease	☐	☐	Have you or do you use:	☐	☐
Eye Problems	☐	☐	Nervous Disorder	☐	☐	Alcohol	☐	☐
Fainting Spells	☐	☐	Pneumonia	☐	☐	Drugs (illicit)	☐	☐
Frequent Headaches	☐	☐	Rectal Disease	☐	☐	Cigarettes	☐	☐

	YES	NO
Have you ever had a work-loss injury or illness?	☐	☐
Are you, at present, under a doctor's care for any condition?	☐	☐
Do you have chronic draining sores or infections?	☐	☐
Military record with medical or dishonorable discharge?	☐	☐
Do you see a dentist regularly?	☐	☐
Do you wear glasses?	☐	☐
Do you wear contact lenses?	☐	☐

Please comment on all YES answers above:

_____

_____

_____

Hospitalization, Surgeries, Injuries: (list with date)

Date		Date	

Medications:

_____

_____

_____

_____

I, THE UNDERSIGNED, CERTIFY THE ABOVE ANSWERS ARE TRUE AND GIVE THE EXAMINING PRIMARY CARE PROVIDER PERMISSION TO SUBMIT A REPORT TO IU SOUTH BEND COLLEGE OF HEALTH SCIENCES.

Student Signature: _____ Date: _____

Physician/Nurse Practitioner-Please complete this page

Height: _____ Weight: _____ BMI:_____ Temperature: _____ Pulse: _____ Respirations: _____ B/P: _____

Hearing:

Complete audiogram only if patient failed whisper test:

Record distance from patient at which forced whispered voice can first be heard.	Right Ear Feet			Left Ear Feet		
Audiometric test record decibel loss at	500Hz	1000Hz	2000Hz	500Hz	1000Hz	2000Hz

VISION	LEFT	RIGHT	BILATERAL	
-Acuity	_____	_____	_____	(uncorrected or corrected)
-Peripheral	_____	_____	_____	

-Color Normal or Abnormal

	Normal	Abnormality (Details of All Abnormal Findings)
General		
Head		
Eyes		
Ears		
Nose		
Throat		
Neck		
Chest/Pulmonary		
Cardiovascular		
Abdomen		
Rectal (optional)		
Genitourinary		
Inguinal Hernia		
Back		
Extremities		
Lymphatic		
Neurologic		
Skin		
Mental Status Exam		

Medical Recommendation: in terms of being a clinical student

A. _____ No significant abnormalities; no medical/student work restrictions.
B. _____ Finding Correctable and/or not serious. Medically will allow anticipated work.
C. _____ Medical findings requiring moderate work restrictions.
D. _____ Medical findings requiring major work restrictions.

I verify that the above named applicant is free from communicable disease.
Yes
No (Please list)
_____

Recommendation: _____

_____

Signature of Primary Care Provider Date

_____ _____

Indiana University South Bend College of Health Sciences

Student Immunization Record

Reviewed by physician or nurse practitioner

Name: _____ Date of Birth: _____Student ID:_____

The following immunizations must be completed or initiated before the beginning of clinicals. Student will not be allowed to attend clinic until these requirements are met.

Proof of immunity to measles, mumps, and rubella is required. If person has received the MMR vaccination, give dates here for initial and booster doses.

1. _____ 2. _____

If no MMR given, document immunity below:

RUBELLA TITRE:
Date Drawn _____ Titre Reading _____
If titre less than 1:10, vaccine:
Date given _____

RUBEOLA
(People born after 1957 who have not had physician diagnosed Rubeola must show evidence of receipt of two (2) doses of measles vaccine or other evidence of immunity.)
Date occurred _____ **OR**
Dates of Vaccine:

1. _____ 2. _____

RUBEOLA TITRE:
Date Drawn: _____ Titre Reading: _____

MUMPS
(Mumps immunization is required for all who have no definite knowledge of having had the disease.)
Date Occurred: _____ **OR**
Date Given: _____
Date Given: _____

SEASONAL FLU SHOT
Date given: _____
Serum:_____
Health Care Facility:

DIPHTHERIA/TETANUS/PERTUSSIS:
Must be within ten years and must include ONE Tdap in past history. Date received:_____
If not within 10 yrs and/or no history of Tdap, must receive booster.

Type: Tdap/Td (circle one)
Date Given: _____

VARICELLA (Chicken Pox): Dates of vaccine (2 doses required)

1. _____ 2. _____ **OR**

History of varicella: Yes No Date: _____

Unknown history submit copy of laboratory report with the following noted
Titre Reading: _____ Date:_____

HEPATITIS B VACCINE

Date given: 1. _____

2. _____

3._____

Hepatitis B Titre:

Titre Reading: _____ Date: _____

TUBERCULIN SKIN TEST (PPD) Must be given within the last year and repeated every 12 months. Chest x-ray is required if tuberculin skin test is positive.

Date Given: _____ Results: _____
Date Read: _____ READ BY: _____

Health Care Facility: _____

If positive reading:
Chest film result: _____