Dwight Schar College of Nursing and Health Sciences Health Record

This packet contains **REQUIRED** health record forms for students enrolling in the **Traditional BSN Nursing Program and The Accelerated Nursing Program**. This four part form is mandatory for all clinical and lab experiences and must be uploaded to the TYPHON student management system at Ashland University. **Do not FAX or mail forms – TYPHON upload is mandatory.**

**Parts 1 and 2 of 4: Medical History and Physical Form**
Completing this will allow us to provide the very best care for you once you are a student at Ashland University. If you have a condition requiring continuing care, (e.g., diabetes, hypertension, emotional disorders, seizures, etc.) please have your healthcare provider send a letter with his/her suggestions for necessary follow-up, medications, etc.

*You must have a physical exam performed and documents on this form. Take this complete packet to your healthcare provider to review. The healthcare provider must be a Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), or a Nurse Practitioner (NP).*

**Part 3 of 4: Immunization History**
You are required to provide a record of immunizations verified and signed by a healthcare provider. Documentation of the following childhood immunization records is required:
- Polio, Chickenpox/Varicella (history of Chicken pox is not sufficient – must have vaccine series or copy of titer)
- MMR (Measles, Mumps, Rubella) - must have vaccine series or copy of titer
- Tdap (Diphtheria/Tetanus/Pertussis)
- Hepatitis B vaccinations - must have vaccine series or copy of titer
- Meningitis vaccination is recommended
- TB (Tuberculosis) Screening, annually - see Ashland University Tuberculosis Screening Requirements form for specific details

Acceptable health records for immunizations include copies of a medical record from a healthcare provider/agency with the student name, immunization given, and the date administered. Contact information for the healthcare provider/agency should be evident. Students should contact the healthcare provider of their choice to meet this requirement.

**Part 4 of 4: Insurance Information**
Complete the Insurance Information form and attach a photocopy of both sides of your medical insurance card if you have private insurance. If you plan to purchase the medical insurance offered through Ashland University, indicate this in the appropriate place.

For more information related to Student Health and Clinical Requirements, review the Nursing Program Student Handbook
PART 1 of 5: MEDICAL HISTORY – TO BE COMPLETED AND SIGNED BY APPLICANT.

NAME _______________________________________________________ ____________________________

SOCIAL SECURITY NO. ____________________________________________

ADDRESS ______________________________________________________ ____________________________________________ ____________________________________________

STREET OR RFD CITY STATE ZIP CODE

DATE OF BIRTH ________________________ COUNTRY OF BIRTH ________________________ STUDENT CELL PHONE ________________________

PERSON TO NOTIFY IN AN EMERGENCY ______________________________________________________ RELATIONSHIP ________________________

(Parent, Guardian or Spouse)

ADDRESS OF ABOVE ______________________________________________________ HOME PHONE ________________________

CELL PHONE ________________________ WORK PHONE ________________________

PERSONAL HEALTH HISTORY

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING:

(In lines of multiple statements, cross out the inapplicable words.)

EXPLAIN ALL ANSWERS BELOW

CHECK EACH ITEM YES NO CHECK EACH ITEM YES NO

CHICKEN POX □ □ SEIZURES/CONVULSIONS □ □

RHEUMATIC FEVER □ □ HIGH BLOOD PRESSURE □ □

HEART PROBLEMS □ □ HIV □ □

SKIN PROBLEMS □ □ TUBERCULOSIS □ □

ALLERGIES/HAY FEVER □ □ MIGRAINE HEADACHE □ □

ARTHRITIS □ □ TOBACCO USE □ □

THYROID PROBLEMS □ □ EMOTIONAL / MENTAL PROBLEMS □ □

STOMACH OR BOWEL PROBLEMS □ □ MUMPS □ □

BLOOD DISORDER □ □ MEASLES □ □

DIABETES □ □ SURGERY □ □

ASTHMA □ □ ALCOHOL/DRUG ABUSE □ □

HEPATITIS/JAUNDICE □ □ KIDNEY/BLADDER □ □

ORTHOEDIC PROBLEMS □ □

IF YES, OR ANY OTHER DISEASE/PROBLEMS, GIVE DETAILS:

________________________________________________________________________

________________________________________________________________________

STATEMENT OF AUTHORIZATION

While a student at Ashland University, I authorize and request Ashland University Student Health Center to administer out-patient and in-patient medical, surgical services and immunizations, and to perform emergency procedures as necessary, or to refer to duly licensed medical personnel when indicated, including transfer to outside hospitals.

Signature of Student __________________________________________________________

Date ________________________________________________________________________

Signature of Parent or Guardian (If under legal age of adulthood in Ohio) ____________________________

Date ________________________________________________________________________

STUDENT MUST UPLOAD FORM PAGES 1-4 TO TYPHON SYSTEM
DO YOU KNOW OF ANY MEDICATION STUDENT IS ALLERGIC TO? □ □ YES □ □ NO

IS THE STUDENT ON MEDICATION? □ □ YES □ □ NO

*THIS STUDENT IS CAPABLE OF PERFORMING THE REQUIRED ESSENTIAL FUNCTIONS FOR CLINICAL COURSE WORK (SEE PAGE 8)

DO YOU HAVE ANY SPECIAL INSTRUCTIONS FOR THE HEALTH CENTER WHILE THE STUDENT IS IN SCHOOL? □ □ YES □ □ NO

STUDENT MUST UPLOAD FORM PAGES 1-4 TO TYPHON SYSTEM
PART 3 of 5: TO BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER

<table>
<thead>
<tr>
<th>VACCINATION RECORD</th>
<th>Dose #1 Date</th>
<th>Dose #2 Date</th>
<th>Dose #3 Date</th>
<th>Date of Positive Immune Titer</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. MMR (Measles, Mumps, Rubella)</td>
<td></td>
<td></td>
<td>NA</td>
<td>Submit actual titer results</td>
</tr>
<tr>
<td>Measles – 2 Doses REQUIRED</td>
<td></td>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Mumps – 2 Doses REQUIRED</td>
<td></td>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Rubella – 2 Doses REQUIRED</td>
<td></td>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>B. Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Doses REQUIRED</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Polio - 4 Doses in Series REQUIRED</td>
<td>Dose #1</td>
<td>Dose #2</td>
<td>Dose #3</td>
<td>Dose #4</td>
</tr>
<tr>
<td>D. Varicella Zoster (Chickenpox) Serology REQUIRED</td>
<td>Titer Date:</td>
<td>□ Immune</td>
<td>□ Non-Immune</td>
<td>Submit actual titer results, if done. History of chickenpox is not sufficient</td>
</tr>
<tr>
<td>Positive Immune Titer or Immunizations (2-dose series)</td>
<td>Dose #1 Date:</td>
<td>Dose #2 Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Tdap (Tetanus/Diphtheria/Whooping Cough) REQUIRED within the last 10 years</td>
<td>Dose Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Meningitis (meningococcal) RECOMMENDED</td>
<td>Dose Date:</td>
<td>□ Menactra (conjugate) OR</td>
<td>□ Menomune (polysaccharide)</td>
<td>□ Menveo (polysaccharide)</td>
</tr>
</tbody>
</table>

By completing this table, I have verified the required immunizations have been given and administered.

Health Care Provider Signature

Printed Name

Date

Agency & Address/Stamp

***

Note: Acceptable health records for immunizations include completing the immunization history and health care provider signature verification OR copies of a medical record from a health care provider/agency with the student name, required immunization given and the date administered. A copy of an acceptable medical record may be attached to this immunization document.

STUDENT MUST UPLOAD FORM PAGES 1-4 TO TYPHON SYSTEM
PART 5 of 5: INSURANCE INFORMATION:

STUDENT NAME: (PLEASE PRINT) ____________________________________________

LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER: ____________________________ DATE OF BIRTH: __________

PLEASE INDICATE WHAT INSURANCE COVERAGE YOU HAVE:

☐ STUDENT INSURANCE – AVAILABLE THROUGH ASHLAND UNIVERSITY
☐ PRIVATE INSURANCE THROUGH A PARENT/SPOUSE – PLEASE COMPLETE THE INFORMATION BELOW
☐ BOTH STUDENT INSURANCE AND PRIVATE INSURANCE – PLEASE COMPLETE THE INFORMATION BELOW

PRIMARY INSURANCE – Please attach a current copy of your private insurance card (front and back views).

NAME OF INSURED ____________________________________________________________ SSN ____________________________

ADDRESS ____________________________ CITY ____________________________ STATE ______ ZIP __________

PHONE ____________________________ RELATIONSHIP OF INSURED TO STUDENT

EMPLOYER _________________________________________________________________

ADDRESS ____________________________ CITY ____________________________ STATE ______ ZIP __________

EMPLOYER’S PHONE ____________________________

INSURANCE COMPANY

__________________________________________________________

ADDRESS ____________________________ CITY ____________________________ STATE ______ ZIP __________

PHONE ____________________________ POLICY NO. __________________________

SECONDARY INSURANCE

NAME OF INSURED ____________________________________________________________ SSN ____________________________

ADDRESS ____________________________ CITY ____________________________ STATE ______ ZIP __________

PHONE ____________________________ RELATIONSHIP OF INSURED TO STUDENT

EMPLOYER _________________________________________________________________

ADDRESS ____________________________ CITY ____________________________ STATE ______ ZIP __________

EMPLOYER’S PHONE ____________________________

INSURANCE COMPANY

__________________________________________________________

ADDRESS ____________________________ CITY ____________________________ STATE ______ ZIP __________

PHONE ____________________________ POLICY NO. __________________________

GROUP NO. __________________________

STUDENT MUST UPLOAD FORM PAGES 1-4 TO TYPHON SYSTEM