This packet contains **REQUIRED** health record forms for students enrolling in the Traditional BSN Nursing Program at the Dwight Schar College of Nursing & Health Sciences at Ashland University. This packet is mandatory for all clinical and lab experiences and must be turned in prior to your second term of enrollment at Ashland University. Please review and complete each of the five sections and return them to:

Send completed forms to:

Clinical Coordinator | Dwight Schar College of Nursing & Health Sciences | 1020 S. Trimble Rd. | Mansfield, Ohio 44903
Fax: 419.521.6826 | Phone: 419.521.6800

**Parts 1 and 2 of 5: Medical History and Physical Examination 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 health care provider send a letter with his/her suggestions for necessary follow-up, medications, etc. You must have a physical exam performed and documented on this form. **Take this complete packet to your health care provider to review.**

The health care provider must be a Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), or a Nurse Practitioner (NP). This physical can also be done at Ashland University Student Health during the first week or two of your first semester. There is a fee for this physical. Please call 419.289.5200 to schedule an appointment.

**Part 3 of 5: 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, MMR (Measles, Mumps, Rubella), Tdap (Diphtheria/Tetanus/Pertussis), and Hepatitis B vaccinations. Meningitis vaccination is recommended.

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

**Part 4 of 5: Tuberculosis Risk Assessment and Screening**
Please complete Section A (Risk Assessment) of this form. If you answer “No” to all 10 questions, you will not need a Tuberculin Skin Test (TST) at this time. If any of your answers are “Yes”, please contact your health care provider or local health department for Two-step TST. Results should be documented in “Section B (and/or C) on this form.

A TST is required for all nursing students by the 4th term of enrollment.

*Note: If you are a health care worker with documentation of a negative yearly TST for the last two consecutive years, then only a one step TST is required.

**Part 5 of 5: Insurance Information**
Please 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, please indicate this in the appropriate spot.

For more information related to Student Health and Clinical Requirements, please review your Pre-licensure Nursing Student Handbook.
• **Gross Motor Skills**: Students must be able to move within confined spaces, sit and maintain balance, stand and maintain balance, reach above shoulders (IVs), and reach below waist (plug-ins).

• **Fine Motor Skills**: Students must be able to pick up objects with hands, grasp small objects with hands, write with pen or pencil, key/type (use a computer), pinch/pick or otherwise work with fingers (syringe), twist (turn knobs with hands), and squeeze with finger (eyedropper).

• **Physical Endurance**: Students must be able to stand (e.g., at client side during procedure), sustain repetitive movements (e.g., CPR) and maintain physical tolerance (work entire shift).

• **Physical Strength**: Students must be able to push and pull 25 pounds (position clients), support 25 pounds of weight (ambulate client) lift 25 pounds (transfer client), move light objects up to 10 pounds, move heavy objects weighing from 10-50 pounds, defend self against combative client, carry equipment/supplies, use upper body strength (e.g., CPR and restrain a client), and squeeze with hands (fire extinguisher).

• **Mobility**: Students must be able to twist, bend, stoop/squat, move quickly, climb ladders, stools and stairs, and walk.

• **Hearing**: Students must be able to hear normal speaking level sounds, hear faint voices, hear faint body sounds (BP), hear in situations not able to see lips (e.g., when using masks), and hear auditory alarms.

• **Visual**: Students must be able to see objects up to 20 inches away, see objects up to 20 feet away, see objects more than 20 feet away, use depth perception, use peripheral vision, distinguish color, and distinguish color intensity.

• **Tactile**: Students must be able to feel vibrations (pulse), detect temperature, feel differences in surface characteristics (e.g., skin turgor), feel differences in sizes and shape (e.g., palpate vein), and detect environmental temperature.

• **Smell**: Students must be able to detect odors from clients, detect smoke and detect gases or noxious smells.

• **Reading**: Students must be able to read and understand written documents.

• **Arithmetic Competence**: Students must be able to read and understand columns of writing (e.g., flow sheets); read digital displays; read graphic printouts (e.g. I&O); calibrate equipment; convert numbers to/from metric; read graphs (e.g., vital sign sheets); tell time; measure time (duration); count rates (e.g., pulse rate); use measuring tools (e.g., thermometer); read measurement marks (e.g., scales); add, subtract, multiply, divide, and compute fractions (medication dosages); use a calculator; and write numbers in records.

• **Emotional Stability**: Students must be able to establish therapeutic boundaries, provide client with emotional support, adapt to changing environment/stress, deal with the unexpected (e.g., crisis), focus attention on task, monitor own emotions, perform multiple responsibilities concurrently, and handle strong emotions (e.g., grief/anger).

• **Analytical Thinking**: Students must be able to transfer knowledge from one situation to another, process information, evaluate outcomes, problem solve, prioritize tasks, use long term memory, and use short term memory.

• **Critical Thinking Skills**: Students must be able to identify cause-effect relationships, plan/control activities for others, synthesize knowledge and skills, and sequence information.

• **Interpersonal Skills**: Students must be able to negotiate interpersonal conflict, respect differences in clients, establish rapport with clients, and establish rapport with co-workers.

• **Communication Skills**: Students must be able to teach (client, family), explain procedures, give oral reports, interact with others, speak on the telephone, influence people, direct activities of others, and convey information through writing (e.g., progress notes).
ASHLAND UNIVERSITY HEALTH RECORD  
Dwight Schar College of Nursing & Health Sciences

PART 1 OF 4: MEDICAL HISTORY - TO BE COMPLETED AND SIGNED BY APPLICANT.

<table>
<thead>
<tr>
<th>NAME</th>
<th>SOCIAL SECURITY NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST</td>
<td>FIRST</td>
</tr>
<tr>
<td>MIDDLE</td>
<td></td>
</tr>
</tbody>
</table>

ADDRESS

<table>
<thead>
<tr>
<th>STREET OR RFD</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
</table>

DATE OF BIRTH __________________________ COUNTRY OF BIRTH __________________________ STUDENT CELL PHONE __________________________

PERSON TO NOTIFY IN AN EMERGENCY ____________________________________________ RELATIONSHIP __________________________

(address of above) ____________________________________________________________________________ HOME PHONE __________________________ WORK PHONE __________________________

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 __________________________

FAMILY HEALTH HISTORY

<table>
<thead>
<tr>
<th>CHECK EACH ITEM</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>TUBERCULOSIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIABETES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIGH BLOOD PRESSURE/STROKE</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CHECK EACH ITEM</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEART TROUBLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CANCER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASTHMA, HAY FEVER, HIVES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHECK EACH ITEM</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPILEPSY OR CONVULSIONS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NERVOUS OR MENTAL DISORDER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLEEDING/CLOTTING DISORDER</td>
<td></td>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>CHECK EACH ITEM</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHICKEN POX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RHEUMATIC FEVER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEART PROBLEMS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SKIN PROBLEMS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALLERGIES/HAY FEVER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARTHRITIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THYROID PROBLEMS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STOMACH OR BOWEL PROBLEMS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLOOD DISORDER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIABETES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASTHMA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEPATITIS/JAUNDICE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORTHOPEDIC PROBLEMS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

CHECK EACH ITEM | YES | NO | IF YES, LIST:
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>DO YOU TAKE MEDICATION?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARE YOU ALLERGIC TO ANY MEDICATIONS?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARE YOU ALLERGIC TO ANY FOODS?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 __________________________

PSP5745.213

Return all Five parts of this document to the Clinical Coordinator, College of Nursing.
PHYSICAL EXAMINATION

PART II: TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER.

PRINT NAME ______________________________________________________________________ DATE __________________________

LAST FIRST MIDDLE

BLOOD PRESSURE _____________  HEIGHT _____________  BUILD:  ❑ SLENDER  ❑ HEAVY  ❑ MEDIUM  ❑ OBESE

PULSE ______________________  WEIGHT ____________  SEX ❑ M  ❑ F  AGE ___________

VISION: WITHOUT GLASSES LEFT 20/ _______  RIGHT 20/ _______  HEARING: RIGHT _______ 15  LEFT _______ 15

WITH GLASSES LEFT 20/ _______  RIGHT 20/ _______

IF CORRECTION IS NEEDED, PLEASE REFER IMMEDIATELY.

CLINICAL EVALUATION

*Evaluation must take into consideration the Required Essential Functions for Clinical Coursework (see attached form)

CHECK EACH ITEM IN PROPER COLUMN, ENTER “N.E.”

NOTE: GIVE DETAILS OF EACH ABNORMALITY. ENTER CORRESPONDING ITEM NUMBER BEFORE EACH COMMENT.

1. HEAD, NECK, FACE, AND SCALP

2. NOSE AND SINUSES

3. MOUTH, TEETH, GINGIVA, AND THROAT

4. EARS—GENERAL (CANALS, DRUMS, ETC.)

5. EYES—GENERAL (LIDS, PUPILS, MOTIONS, ETC.)

6. LUNGS, CHEST, AND BREASTS

7. HEART (INCLUDE ESTIMATE OF CARDIAC FUNCTION)

8. VASCULAR SYSTEM (INCLUDE VARICOSITIES)

9. ABDOMEN AND VISCERA (INCLUDE HERNIA)

10. ANO-RECTAL AND PILONIDAL

11. ENDOCRINE SYSTEM

12. GENITO-URINARY SYSTEM

13. UPPER EXTREMITIES

14. LOWER EXTREMITIES (INCLUDE FEET)

15. SPINE, OTHER MUSCULOSKELETAL

16. SKIN AND LYMPHATIC (INCLUDE ACNE)

17. NEUROLOGICAL SYSTEM

18. PSYCHIATRIC (SPECIFY ANY PERSONALITY DEVIATION)

19. IF FEMALE, GIVE MENSTRUAL HISTORY—SPECIFY MEDICATION

DOCTOR DO YOU

CHECK EACH ITEM  YES NO

DO YOU KNOW OF ANY MEDICATION STUDENT IS ALLERGIC TO? ❑ ❑

IF SO, WHAT ________________________________

DO YOU HAVE ANY SPECIAL INSTRUCTIONS FOR THE HEALTH CENTER WHILE THE STUDENT IS IN SCHOOL? ❑ ❑

IS THE STUDENT ON MEDICATION? ❑ ❑

IF SO, WHAT ________________________________

*This student is capable of performing the Required Essential Functions for Clinical Coursework.

HEALTH CARE PROVIDER SIGNATURE (MD, DO, PA, OR NP)

ALSO, PLEASE PRINT, STAMP OR TYPE NAME

ADDRESS

CITY STATE ZIP CODE

PHONE

OVER

PSP5745.213
# IMMUNIZATION HISTORY

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

## VACCINATION RECORD

<table>
<thead>
<tr>
<th>Dose #1 Date</th>
<th>Dose #2 Date</th>
<th>Dose #3 Date</th>
<th>Date of Positive Immune Titer</th>
</tr>
</thead>
</table>

### A. MMR (Measles, Mumps, Rubella)
- 2 Doses REQUIRED

### -OR-

- Measles – 2 Doses REQUIRED
- Mumps – 2 Doses REQUIRED
- Rubella – 2 Doses REQUIRED

### B. Hepatitis B
- 3 Doses REQUIRED

### C. Polio
- REQUIRED

### D. Varicella Zoster (Chickenpox) Serology
- REQUIRED

- Positive Immune Titer or Immunizations (2-dose series)
  - Titer Date
  - Episode: Immune | Non-Immune
  - Dose #1 Date | Dose #2 Date

### E. Tdap (Tetanus/Diphtheria/Whooping Cough)
- REQUIRED within the last 10 years
  - Dose Date

### F. Meningitis (Meningococcal)
- Recommended
  - Dose Date
  - Menactra (conjugate) OR
  - Menomune (polysaccharide)
  - Menveo (polysaccharide)

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.
ASHLAND UNIVERSITY HEALTH RECORD

PART 3 OF 4: TUBERCULOSIS RISK ASSESSMENT AND SCREENING

STUDENT NAME__________________________________________________________

A: RISK ASSESSMENT

1. HAVE YOU HAD RECENT CLOSE CONTACT WITH SOMEONE WHO HAS INFECTIOUS TB?
   □ YES     □ NO

2. WERE YOU BORN IN, OR HAVE YOU RECENTLY TRAVELED TO AN AREA WITH A
   HIGH-PREVALENCE OF TB? (AFRICA, ASIA, EASTERN EUROPE OR CENTRAL
   SOUTH AMERICA) – A FULL LIST OF COUNTRIES IS AVAILABLE AT:
   WWW.ASHLAND.EDU/STUDENTS/CAMPUS-LIFE/HEALTH-SERVICES
   □ YES     □ NO

3. HAVE YOU HAD AN ABNORMAL CHEST X-RAY SUGGESTING INACTIVE OR
   PAST TB DISEASE?
   □ YES     □ NO

4. DO YOU HAVE HIV OR AIDS?
   □ YES     □ NO

5. ARE YOU AN ORGAN TRANSPLANT RECIPIENT?
   □ YES     □ NO

6. ARE YOU IMMUNOSUPPRESSED (EQUIVALENT OF >15MG OF PREDNISONE
   FOR >1 MONTH, OR TNF-ALPHA ANTAGONIST)?
   □ YES     □ NO

7. ARE YOU A RESIDENT (OR RECENT RESIDENT), EMPLOYEE OR VOLUNTEER IN
   A HIGH-RISK CONGREGATE SETTING (E.G., CORRECTIONAL FACILITIES,
   NURSING HOMES, HOMELESS SHELTERS, HOSPITALS OR OTHER
   HEALTH CARE FACILITIES)?
   □ YES     □ NO

8. DO YOU HAVE A MEDICAL CONDITION ASSOCIATED WITH INCREASED RISK OF
   PROGRESSING TO TB DISEASE IF INFECTED [E.G., DIABETES, SILICOSIS, HEAD
   NECK, OR LUNG CANCER, HODGKIN'S DISEASE, LEUKEMIA, ETC.]?
   □ YES     □ NO

9. DO YOU HAVE SIGNS OR SYMPTOMS OF ACTIVE TUBERCULOSIS DISEASE?
   (COUGH, FEVER, NIGHT SWEATS, CHEST PAIN, COUGHING UP BLOOD)
   □ YES     □ NO

B: TUBERCULIN SKIN TEST (TST). THIS WILL BE ADMINISTERED AT THE COLLEGE OF NURSING ONCE YOU ARE ENROLLED.

TST RESULT SHOULD BE RECORDED AS ACTUAL MILLIMETERS (MM) OF INDURATION, TRANSVERSE DIAMETER; IF NO INDURATION, WRITE “0”.
THE TST INTERPRETATION SHOULD BE BASED ON MM OF INDURATION AS WELL AS RISK FACTORS.
* IF TB TEST IS POSITIVE, THE STUDENT WILL NEED A CHEST X-RAY

DATE MANTOUX (TST) GIVEN:__________ DATE READ:__________
RESULT: _____MM OF INDURATION INTERPRETATION: □ POSITIVE* □ NEGATIVE
SIGNATURE: _________________________ PHONE:_____________________

C: CHEST X-RAY (REQUIRED IF TST IS POSITIVE) DATE OF CXR__________
RESULT □ NORMAL □ ABNORMAL - ATTACH COPY OF CHEST X-RAY RESULTS

Return all Five parts of this document to the Clinical Coordinator, College of Nursing.
PART 4 OF 4: INSURANCE INFORMATION

STUDENT____________________________________________________________

SOCIAL SECURITY NO.____________________________________ 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 __________________________________________ EMPLOYER’S PHONE ________________________

EMPLOYER’S ADDRESS _____________________________________ CITY________________ STATE______ ZIP________

INSURANCE COMPANY ______________________________________

ADDRESS _________________________ CITY________________ STATE______ ZIP _________________

INSURANCE COMPANY PHONE ________________________________

POLICY NO. __________________________________________________________________ GROUP NO.____________

SECONDARY INSURANCE:

NAME OF INSURED __________________________________________ SSN________________________________

ADDRESS _________________________ CITY________________ STATE______ ZIP _________________

PHONE ___________________________ RELATIONSHIP OF INSURED TO STUDENT___________________________

EMPLOYER __________________________________________ EMPLOYER’S PHONE ________________________

EMPLOYER’S ADDRESS _____________________________________ CITY________________ STATE______ ZIP________

INSURANCE COMPANY ______________________________________

ADDRESS _________________________ CITY________________ STATE______ ZIP _________________

INSURANCE COMPANY PHONE ________________________________

POLICY NO. __________________________________________________________________ GROUP NO.____________