TRINITY COLLEGE
OF NURSING & HEALTH SCIENCES
Medical Examination

_____ _____ _____ _____
Last Name First Name Middle Name Social Security Number

_____ _____ _____
Educational Program Start Date (MM/YY) Date of Birth (MM/DD/YY)

I, _____ (Student Signature) authorize release of medical information to Trinity College of Nursing and Health Sciences.

Please note that the remainder of this form must be filled out and signed by a physician or licensed practitioner.

Gender: _____ Height: _____ Weight: _____

Temperature: _____ Pulse: _____ Respiration: _____ Blood Pressure: _____

Eyes/Vision: O.S _____ O.D. _____ Glasses/Contacts: YES NO

Corrected Vision: O.S. _____ O.D. _____

Ears: Normal _____ Impaired_____ Hearing Aid YES NO

Throat, Tonsils, Thyroid: _____

Skin: _____

Skeletal:_____

Heart: _____ Lungs: _____

Chest: _____ Lymph Nodes: _____

Abdomen: _____ Hernia: _____

Rectal: _____ Prostate/Vaginal_____

Nervous System: Reflexes:_____ Balance: _____ Coordination: _____ Gait: _____

Family History: _____

History of Mental Illness: _____

Menstrual History: _____

Allergies: _____

_____

Drug Reaction or Sensitivity: _____

_____

Summary: _____

_____

_____

List any health-related problems/surgeries that would prohibit the learner from completing a health education program?

_____

_____

--OVER--

The following immunizations are required prior to enrolling at Trinity College of Nursing and Health Sciences.

Immunization	**First**	**Second**	**Third**	**Booster**
Diphtheria, Pertussis, Tetanus (DPT) (DT)	_____	_____	_____	_____
Tetanus Diphtheria Booster or (TD) {TD Booster is required every 10 years}			_____	_____

VARICELLA

Varicella immunity can be documented by: a stated history of the disease from the student, records of the immunization against Varicella, or positive results of a Varicella antibody titer.

Varicella (Chickenpox) Disease Date:_____ **OR**

Immunization #1 _____

Immunization #2 _____

Vaccination required for health care providers unless documented immunity. *Immunity cam be documented by: a physician's statement that the student was treated for the disease, records of two immunizations against measles, mumps, & rubella, or positive results of antibody titers for all three diseases.*

Measles, Mumps, Rubella (MMR) Vaccination #1 _____ Vaccination #2 _____

OR Mumps Titer Date_____ Measles Titer Date _____ Rubella Titer Date _____

Doctor documented date of disease: Mumps _____ Measles _____ Rubella _____

TUBERCULOSIS

Testing required for all Illinois health care providers (within three months prior to entrance of program)

Tuberculin (Mantoux – 2 Step) 1 week apart

Step One Date _____ Result _____

Date Two Date _____ Result _____

Hepatitis B Vaccination (Must have at least one before entry into School Program)

Number	Date of Vaccination	Vaccination Lot Number	Dosage	Site of Vaccination	Vaccination Given by/Signature
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____

Hepatitis B titer required. Hepatitis B titer should be drawn at least 1 month following completion of Hepatitis B series.

Hepatitis B Titer Date:_____ Titer Results: _____

If starting series, please submit this form after the first injection and provide written proof of second and third injections and titer after each completion.

I have given _____ a careful physical examination and found the individual to be in _____ health.

_____ _____

Signature of Physician or Licensed Practitioner Date of Examination

_____ _____

Street Address Office Telephone Number

_____

City/State/Zip Code

NOTE: **The student should return this completed form directly to:**

Trinity College
of Nursing & Health Sciences
Attention: Student Services
2122 25th AVE
Rock Island, IL 61201-5317