UNIVERSITY OF SAINT JOSEPH
CONNECTICUT

HEALTH PROFESSIONS STUDENT HEALTH FORM

FRESHMAN NURSING STUDENTS: DO NOT CONTINUE WITH THIS FORM
PLEASE COMPLETE THE UNDERGRADUATE STUDENT HEALTH FORM

I. TO BE COMPLETED BY STUDENT (REQUIRED)

NAME _____ DOB _____ ID # _____

PROGRAM: ( ) NURSING ( ) PHARMACY ( ) PHYSICIAN ASSISTANT ( ) DIETETIC INTERNSHIP

II. TO BE COMPLETED BY STUDENT'S HEALTH CARE PROVIDER (REQUIRED)

A. REQUIRED IMMUNIZATION HISTORY or attach official immunization record

MMR – no birthdate exemption	#1 (date)	#2 (date)	
MMR – *2 doses, at least 28 days apart, at or after 12 months of age*			
-- **OR** --	#1 (date)	#2 (date)	
Measles - *2 doses as above*			
Mumps - *2 doses as above*			
Rubella - *2 doses as above*			
-- **OR** --			
Measles Titer – *must attach lab results*	Date	Result	
Mumps Titer – *must attach lab results*	Date	Result	
Rubella Titer – *must attach lab results*	Date	Result	
VARICELLA – no birthdate exemption	#1 (date)	#2 (date)	
Varicella – *2 doses, at least 28 days apart*			
-- **OR** --			
History of Chicken Pox disease *(titer also required for PA students)*	Date of disease		
-- **OR** --			
Varicella Titer – *must attach lab results*	Date	Result	
HEPATITIS B	#1 (date)	#2 (date)	#3 (date)
Hepatitis B			
	#4 (date)	#5 (date)	#6 (date)
Hepatitis B Repeat Series, *if applicable*			
-- **OR** --			
Hepatitis B Titer – *must attach lab results*	Date	Result	
TETANUS	date		
Tdap – *one adult dose required (do not include DTP or DTaP here)*			
Td Booster – *required if Tdap dose given 10 or more years ago*			
INFLUENZA – required for PA students	date		
Current seasonal influenza vaccine			
MENINGOCOCCAL ACYW - required to live on campus	#1 (date)	#2 (date)	
One dose within the 5 years prior to arrival on campus			

STUDENT NAME & ID # _____

B. OPTIONAL IMMUNIZATION HISTORY

SEROGROUP B MENINGOCOCCAL - recommended	#1 (date)	#2 (date)	#3 (date)
Vaccine:			

POLIO	#1 (date)	#2 (date)	#3 (date)	#4 (date)
Vaccine:				

HEPATITIS A	#1 (date)	#2 (date)
Hepatitis A Vaccine		

HUMAN PAPILLOMAVIRUS (HPV)	#1 (date)	#2 (date)	#3 (date)
HPV Vaccine			

PNEUMOCOCCAL	date
PCV 13 - *most recent dose*	
PPSV 23 – most recent dose, if applicable	

C. PHYSICAL EXAM (REQUIRED)

DATE OF EXAM: _____ (***must be within one year of entry)***

ALLERGIES: _____

Blood Pressure: _____ Pulse _____ BMI _____

Visual Acuity Screening OS _____ OD _____ OU _____ ( ) corrected

Color Blindness Screening (required for nursing students only) ( ) pass ( ) fail ( ) not performed

STUDENTS IN NEED OF ACCOMMODATIONS RELATED TO A DISABILITY ARE ADVISED TO CONTACT THE OFFICE OF ACCESSIBILITY SERVICES: Accessibility@usj.edu

D. TUBERCULOSIS SCREENING (REQUIRED) – SEE SEPARATE FORM

STUDENTS MUST ALSO COMPLETE THE HEALTH PROFESSIONS TB SCREENING QUESTIONNAIRE

E. MEDICAL HISTORY FORM (REQUIRED) – SEE SEPARATE FORM

STUDENTS MUST ALSO COMPLETE THE MEDICAL HISTORY FORM / NO PROVIDER SIGNATURE NEEDED

F. FITNESS FOR DUTY (REQUIRED)

Please indicate if this student is able to perform the following functions of their academic program with or without reasonable accommodations:

( ) Conduct professional observations and collect patient data
( ) Use medical devices and perform typical procedural tasks
( ) Successfully communicate with patients, clients, and other members of the health care team
( ) Work in stressful environments or situations and with patients or clients experiencing distress or difficulty
( ) Lift up to 45 pounds

G. HEALTH CARE PROVIDER (MD/DO/NP/PA) ATTESTATION (REQUIRED)

By signing below, you attest that the above immunization and physical exam information is correct and that this student may fully participate in their academic program with or without reasonable accommodations.

Office Stamp

Name _____

Signature _____ Phone _____

Date _____ Fax _____

Full name, signature, and office contact information is required