NORTHWESTERN STATE UNIVERSITY
College of Nursing

Health Information Record for Clinical Admission (Revised July 2020)

This form must be completed prior to admission to first clinical rotation. Students must keep a copy of this completed record for their own files.

Section A: Student Completes

Name: _____
(Last) (First) (Middle)

DOB: _____ Age: _____ Gender: _____ Last 4 # SSN ____ ____ ____ ___

Student ID Number: _____ University E-mail: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____

Current Mailing Address: _____
Street/P.O. Box

City: _____ State: _____ Zip Code: _____

Permanent Home Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance Company: _____ Policy Number: _____

Policy Holder: _____ Relationship: _____

Program(circle): ASN BSN LPN/PARA-ASN LPN-BSN BS-BSN

Section A continued: STUDENT completes

Do you have a current diagnosis or history of any of the following?

Condition	Yes	No	Comments
Diabetes			
Heart Disease/Hypertension			
Respiratory Disease			
Seizure Disorder			
Paralysis/Paresis			
Orthopedic Problems			
Hearing Loss			
Impaired Vision **(not corrected with frames/contacts)**			
Substance Abuse			
Emotional Problems **(Anxiety, Depression, etc.)**			
Mental Health Disorders **(Bipolar, Schizophrenia, etc.)**			
Learning Difficulties **(ADD/ADHD, Dyslexia, etc.)**			
Other:			

Please list any allergies to Drugs or Food: _____

List any medications you are currently taking, including over the counter and alternative: ***Please note that controlled substances no longer have to be reported to the Louisiana State Board of Nursing, but has to be reported to Northwestern State University, College of Nursing. This form must be updated every semester and with any changes in medication or health history. If you are taking a controlled substance, please also attach a copy of your prescription, physician's note, or pharmacy printout.***

I verify that the above information including physical, mental, and/or emotional conditions has been indicated and disclosed. This information is accurate to my knowledge. I understand that the failure to submit this required record by the designated date as directed will prevent me from attending clinical experiences.

Date:_____ Print Name: _____

Student Signature: _____ Student ID: _____

Student Name: _____ **Student ID:** _____

Section B: Health Care Provider completes (MD, NP, or PA)

Physical Exam

Height:	Weight:		Blood Pressure:		Pulse:	
Hearing:	Normal	Abnormal	Corrected	Comments:		
Vision:	Normal	Abnormal	Corrected	Comments:		

	Normal	Abnormal	Comments
Head, face, scalp			
Eyes			
Ears			
Nose, sinuses			
Oral Cavity			
Neck, lymph nodes, thyroid			
Breasts			
Respiratory			
Cardiovascular			
Abdomen & Inguinal Area			
Musculoskeletal			
Neurologic			
Reflexes			
Other:			

*Signature below verifies the above physical exam was performed and is accurate to the best of your knowledge

Date: _____ Provider Signature: _____

Provider Name: _____

Facility Address: _____

Phone: _____ Fax: _____

This information will be used in instances where the data would affect clinical assignments. The student will maintain full responsibility for the care and follow-up of any diseases, conditions, or needed treatments.

*The following are needed, in addition to the above physical. All obtained data must be collected and documented with an official health record. A copy of **all** lab results and vaccine records must be submitted as specified below.

- Varicella IgG titer report (within 5 years)
- Rubella IgG titer report (within 5 years)
- Hepatitis B Antibody titer report (within 5 years)
- HIV test report (within 1 year)
- TB skin test, T-Sport, or Quantiferon Gold test (completed annually)
- Immunization Record
  - Tetanus Booster (within 10 years)
- Influenza Vaccine record (repeated every flu season)
- CPR/BLS card (every 2 years)

Students working in the healthcare setting, must show immunity to the following diseases: Varicella, Rubella, and Hepatitis B, which is indicated by a **Positive** titer. In the event, titers are negative, students will be required to initiate vaccinations. The only exception will be per MD waiver for medical conditions, in which vaccination is contraindicated or a failure to convert after repeat vaccination.

Immunization schedules are based upon the Center for Disease Control Guidelines (CDC) 2020. Some of the following immunizations are also a requirement of the State of Louisiana R.S.17:170 of 1990, for all students entering schools or higher learning.

All Health Forms and required documentation should be submitted to the Health Services nurse at:
(Shreveport Campus only, all other campuses please submit to designated coordinator)

- Shreveport Health Services
  Northwestern State University
  1800 Line Ave. LC 104
  Shreveport, LA 71101

- FAX: 318.677.3191

- Drop box outside Shreveport Health Services

For information regarding this form and its entirety contact Shreveport Health Services
rogersti@nsula.edu
318.677.3024 (o)