



PRESBYTERIAN SCHOOL OF NURSING

Student Medical Forms (total of 9 pages including this page)

Please return completed forms to

ASN Program: Presbyterian School of Nursing at Queens University
of Charlotte – ASN Program
ATTN: Melinda Armstrong (704-688-2887)
1900 Selwyn Avenue
Charlotte, NC 28274

BSN Program: Presbyterian School of Nursing at Queens University
of Charlotte – BSN Program
ATTN: Annette Hines (704-337-2369)
1900 Selwyn Avenue
Charlotte, NC 28274

ABSN Program: Presbyterian School of Nursing at Queens University
of Charlotte – ABSN Program
ATTN: Jesus Hernandez (704-688-2882)
1900 Selwyn Avenue
Charlotte, NC 28274

To Applicant:

Please fill in the information regarding personal and family history. Your examining physician should complete the remainder of the information. The information that you provide is confidential. It will be kept in your personal health folder for use by professional staff only.

GUIDELINES FOR COMPLETING STUDENT MEDICAL FORMS

- **Records must be documented in ink and any corrections must be signed.**
- **All immunization records must include month, day and year of administration.**
- **History of disease is NOT acceptable. Only positive blood titers or proof of immunization will be accepted.**
- **MD, PA, or NP must complete and sign Physical Examination or it will not be accepted.**
- **Clinician must sign official Immunization Record and include facility stamp or it will not be accepted.**

Required Immunizations – must submit proof

- 3 Tdap (Tetanus, Diphtheria, Pertussis) or Td (Tetanus, Diphtheria) doses, 1 dose within the past 10 years (booster). If enrolling in college for the first time the booster must be Tdap.
- 2 Measles (Rubeola), 1 Mumps, 1 Rubella (MMR is preferred)
- If 50 years old or older, Rubella dose not required.
- 3 Polio (oral) doses – only if 17 years or younger.
- 2 doses Varicella (chicken pox) doses or positive blood titer.
- 2 step* Tuberculin Skin Test (PPD) within 12 mos. of starting classes. Can accept negative chest xray if history of positive PPD.

* 2 step PPD – if initial PPD is negative, second PPD is given 1 to 3 weeks later. Must submit results of both tests.

Please note: “History of disease” is NOT ACCEPTABLE. You must submit proof of administration or positive blood titer.

Highly Recommended – submit proof or sign a declination

- Hepatitis B series – can be completed after classes begin.

Optional Vaccines – not mandatory, no need to submit proof

- Meningococcal
- Pneumococcal
- Hemophilus Influenza B
- Influenza
- Hepatitis A

REPORT OF MEDICAL HISTORY (Please type print in black ink.)

 Last Name First Name Middle Name Social Security Number

 Permanent Address City State Zip Area code / Phone No.

 Date of Birth Gender Marital Status

Entering Class: FR SO JR SR Yr: ____ Semester: Fall Spring Summer

Family Insurance Coverage: Y N Queens Student Coverage: Y N

 Health Insurance Provider Area code / Ph No.

 Name of Policy Holder Social Security No. Employer

 Policy or Certificate No. Group No.

 Name of Emergency Contact Relationship to Student

 Address Area code / Phone No.

The following health history is confidential, does not affect your admission status, and, except in an emergency situation or by court order, will not be released without your written consent. Please attach additional sheets for any item require an explanation.

Family and Personal Health History (Please type or print in black ink.)

Has any person, related by blood had any of the following?

	Y	N	Relative		Y	N	Relative		Y	N	Relative
High blood pressure				Cholesterol or blood fat disorder				Alcohol or Drug problems			
Stroke				Diabetes				Psychiatric illness			
Cancer type _____				Glaucoma				Suicide			
Heart attack before age 55				Blood or clotting disorder							

Have you ever had (or do you now have) any of the following:

	Y	N	Year		Y	N	Year		Y	N	Year
High blood pressure				Mononucleosis				Pneumonia			
Rheumatic fever				Hay fever				Chronic cough			
Pain or pressure in chest				Arthritis				Tuberculosis			
Heart trouble				Concussion				Tumor or cancer			
Shortness of breath				Headaches				Allergy injection therapy			
Asthma				Alcohol / drug addiction				Thyroid trouble			
Smoke 1+ pack cigarettes per week				Rehab				Serious skin disease			
Shoulder dislocation				Dizziness or fainting				Hearing loss			
Recurrent back pain				Paralysis				Severe menstrual cramps			
Knee Problems				Severe head injury				Hernia			
Neck injury				Epilepsy / Seizures				Irregular periods			
Diabetes				Depression / Anxiety				Blood transfusion			
Anorexia / bulimia				Anemia / Sickle Cell Anemia				Bladder / kidney infection			
Eye problem other than glasses				Sexually transmitted disease				Kidney stones			
Broken bones				Back injury							

Please list any medications, vitamins and/or minerals (prescription and non-prescription) you use, and indicate how often you use them.

Name _____ Dosage _____ Name _____ Dosage _____
 Name _____ Dosage _____ Name _____ Dosage _____
 Name _____ Dosage _____ Name _____ Dosage _____

Allergies

Check each item Y or N. Every Y must be fully explained. Use additional sheet if necessary. Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If Y please indicate the type of reaction, your age at the time of reaction and if the reaction has occurred more than once.

	Y	N	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine / other pain reliever			
Other medicines, chemicals			
Insect bites			
Food (name)			

	Y	N	Explanation
Have you ever been a patient in any type of hospital?			
Has your academic career been interrupted due to physical or emotional problems?			
Is there loss or seriously impaired function of any organs?			
Other than for a routine check-up, have you seen a physician or health care professional in the past six months?			
Have you ever had any serious illness or injury other than those already noted?			

Statement by Student:

I have personally supplied the foregoing information and attest that it is true and complete to the best of my knowledge. I hereby give permission to any doctor, hospital, or medical agency to release confidentially to Queens University of Charlotte any information they may have concerning my medical condition and their professional contact with me. I hereby authorize any necessary medical treatment for myself.

Student Signature _____ Date _____

Parents/Guardians of Students Under 18

I hereby authorize any medical treatment for my son/daughter that may be advised or recommended by the physicians or health care professional of the Queens University of Charlotte Health & Wellness Center.

Parent/Guardian Signature _____ Date _____

University Policy for All Students

It is the student's responsibility to keep parents/guardians informed about personal health matters. All reasonable effort will be made to secure the student's permission should the University deem it necessary to communicate with the parents/guardians regarding medical concerns.

IMMUNIZATION RECORD (Required – must be completed & signed by clinician)

Last Name First Name Middle Name Date of Birth

IMMUNIZATION RECORD TO BEGIN NURSING PROGRAM

	Mo/day/yr	Mo/day/yr	Mo/day/yr	Mo/day/yr
DTP or Td	#1	#2	#3	
Td Booster (within last 10 years)	#1			
Oral Polio (if 17 years or younger)	#1	#2	#3	
MMR	#1	#2		
Measles	#1	#2		Blood Titer date & result:
Mumps	#1			Blood Titer date & result:
Rubella	#1			Blood Titer date & result:
Tuberculin Skin Test (PPD)	#1 date/result	#2 date/result		
Chest Xray (if applicable)	date/result			
Varicella (chicken pox – must have 2 doses or positive blood titer)	#1	#2		Blood Titer date & result:
Hepatitis B series (recommended - not required)	#1	#2	#3	Blood Titer date & result:

OPTIONAL VACCINES

	Mo/day/yr	Mo/day/yr	Mo/day/yr
Hepatitis A series			
Hemophilus Influenzae B			
Influenza			
Pneumococcal			
Meningococcal			
Other:			

Clinician signature or clinic stamp (required): _____

Date: _____ Address: _____ Ph. No. _____

CPR REQUIREMENT

While in the nursing program you must maintain continuous CPR certification. This certification must be **BLS for Healthcare Providers** and include the following components:

- Adult CPR and relief of airway obstruction**
- Child CPR and relief of airway obstruction**
- Infant CPR and relief of airway obstruction**
- Automated External Defibrillation (AED)**

Your card must indicate that you were instructed in all the above modules. It must also indicate **your name, the date of your class, and the date your card expires**. Please attach a photocopy of your card below:

(front of card)

(back of card)

You are responsible for submitting a photocopy of your new card before the old card expires.

Drug Screening Record

Consistent with our clinical partners practice regarding a drug free environment, all applicants selected for admission to any program or course in the School of Nursing must provide documentation of a negative (urine), **five panel drug screen** that has been collected and processed using a NIDA-approved laboratory. Chain of custody in handling of the specimen must be maintained. You will not be permitted to enroll in courses unless the drug screen is negative.

You may have this drug screen completed at the Queens University Health and Wellness Center. There is a fee for this service. Please call (704) 337-2220 for an appointment. You may also use your healthcare provider, clinic, or independent laboratory. Please investigate the cost at each provider before having the test performed. **You only need a five panel drug screen.**

Test results should be attached to this sheet.

Last Name	First Name	Middle Name	Date of Birth
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Social Security Number

Results of 5 panel drug screen:

Date of testing

Results (attach lab report)