Dear New Student,

Welcome to Saint Francis Medical Center College of Nursing! I know that you are looking forward to beginning the first steps to become a professional nurse. Congratulations to you!

Attached to this letter are the history, physical, and immunization requirements. To complete your admission process, you must complete the health information three weeks prior to the start of classes. It is important that you begin to work on this information immediately, as several of the requirements may take an extended period of time to complete.

NOTE: Per the policy in the Student Handbook, all students who do not have their health records in by the deadline will not be able to start new student orientation and attend class, clinical, or practicum. In accordance with regulations of the Illinois Department of Public Health and OSF Saint Francis Medical Center, all students are required to present proof of immunity against vaccine preventable diseases. By completing the requirements, you will not only be protecting your own health, but the health of your patients and classmates.

If you have any questions or concerns, please feel free to email me at maureen.d.hermann@osfhealthcare.org.

Thank you and welcome to SFMC College of Nursing!

Sincerely,

Maureen Hermann, RN, BSN
Health Nurse/Practice Lab Assistant
Health History, Physical, & Immunization Forms
Saint Francis Medical Center College of Nursing
511 N. E. Greenleaf Street, Peoria, IL 61603

Student Name: _______________________________ Date: ____________________

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Federal law requires Saint Francis Medical Center College of Nursing and its related health care providers/caregivers to maintain the privacy of individually identifiable health information and to provide you with notice of their legal duties and privacy practices with respect to such information. Saint Francis Medical Center College of Nursing and its related health care providers must abide by the terms and conditions of this law. Saint Francis Medical Center College of Nursing may use or disclose your individually identifiable health information for treatment and health care operations. These categories are involved in delivering the health care services that you seek and the quality and safety of those services. These activities may include release of your health records to the College physician or authorized personnel. I understand the above HIPAA guidelines and approve.

Student Signature/Date:

Latex Sensitivity Health History

1. Do you have a latex allergy?........................................................................................................ (Y/N)
2. Do you have any swelling/itching of your lips after blowing up balloons?................ (Y/N)
3. Have you experienced any swelling/itching after dental, vaginal or rectal exams or using condoms?................................................................................................................................. (Y/N)
4. Do you have any history of eczema or dermatitis of the hands?........................................ (Y/N)
5. Do you have any other skin problems?.................................................................................... (Y/N)
6. Do you have any food allergies?............................................................................................. (Y/N)
7. Do you have any other allergies?............................................................................................ (Y/N)
8. Do you have a history of unexplained nasal congestion, itchy, watery eyes or chest congestion?................................................................................................................................. (Y/N)
9. Have you had multiple surgical procedures as an infant?..................................................... (Y/N)
10. Have you ever experienced any unexplained acute allergic reaction during or after a surgical procedure?................................................................................................. (Y/N)

If you answered (Y) to any of the latex questions, please explain below:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Medical History (To be completed by the Student)

All medical information is strictly confidential. Please answer the questions below. If the answer is yes, please provide details on the space provided.

1. Allergic reactions to any medicines? (Please specify medicine and type of reaction.)

2. Serious reactions to insect bites or food?

3. Infectious Mononucleosis?

4. Chicken Pox?

5. Hepatitis? What type?

6. High Blood Pressure?

7. Heart Murmur? Other cardiac disorders?

8. Diabetes, thyroid or other endocrine disorders?

9. Asthma? Bronchitis?

10. Colitis, abdominal pain, gastric disorders?

11. Shingles?


14. Back pain, disorders of the bone, muscle or joint?

15. Frequent or severe headaches or migraines?

16. Seizure disorder, convulsions, past head injury or concussions?

17. Disabling loss of vision?

18. Do you take medication (prescribed and/or over the counter) on a regular basis? If so, please list below.

19. Have you had any serious dietary problems?

20. Any operations, hospitalizations or serious injuries? Please specify.
Core Performance Standards & Criteria of Admission and Progression

In compliance with the American Disability Act, Saint Francis Medical Center College of Nursing does not discriminate on the basis of disability in the administration of its educational policies, admission policies, student aid and other college administered programs nor in the employment of its faculty and staff. The skills listed below are essential requirements for this program. We invite any potential student to meet with the Dean to discuss any issues associated with meeting or not meeting these requirements.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Standard</th>
<th>Some Examples of Necessary Activities (not all inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical</td>
<td>Thinking Patient Client needs/Problem Solving/Critical Thinking ability</td>
<td>Identify cause-effect relationships in clinical situations. Develop nursing care plan. Make judgment regarding appropriate interventions based on signs and symptoms.</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, economic, religious, cultural, and intellectual backgrounds.</td>
<td>Establish rapport with patients/clients and colleagues and other health care providers.</td>
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<tr>
<td>Communication</td>
<td>Communication proficiency at a competent level in English, both verbal and written, to include reading, writing, spelling, speaking and listening.</td>
<td>Explain treatment procedures, initiate health teaching, document and interpret nursing action and patient/client responses. Document clearly, correctly, and without spelling errors. Read and write at college level.</td>
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<tr>
<td>Mobility</td>
<td>Physical abilities sufficient to provide safe and effective nursing care.</td>
<td>Work in a standing position with frequent walking most of an eight-hour day; bend &amp; stoop, push &amp; pull objects such as a wheelchair, cart, gurney or equipment; lift &amp; transfer clients from a stooped to an upright position.</td>
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<tr>
<td>Motor Skills</td>
<td>Gross and fine motor abilities sufficient to provide safe and effective nursing care.</td>
<td>Calibrate and use equipment; administer medications; position patients/clients.</td>
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<tr>
<td>Hearing</td>
<td>Auditory ability sufficient to monitor and assess health needs, to communicate with individuals, families, groups, communities and health care professionals, and to provide therapeutic interventions accurately.</td>
<td>Hear &amp; respond to verbal communication and requests: respond to emergency signals, auscultatory sounds, percussion and auscultation, and hear cries for help.</td>
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<tr>
<td>Visual</td>
<td>Visual ability sufficient for observation, assessment and provision of nursing care.</td>
<td>Observe and respond to patients/clients and provide therapeutic interventions accurately; closely examine images or other forms of output from diagnostic equipment or patient body fluids; visually discriminate medication and syringe labels; determine variations in skin color of client.</td>
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<tr>
<td>Tactile</td>
<td>Tactile ability sufficient for observation, assessment and provision of nursing care.</td>
<td>Perform palpation and other functions of physical examination or those related to therapeutic intervention, e.g., insertion of a catheter.</td>
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<tr>
<td>Other</td>
<td>Mental alertness sufficient to provide safe, effective nursing care.</td>
<td>Observe and respond to patient/clients and provide therapeutic interventions accurately and safely.</td>
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Adapted from the Southern Council on Collegiate Education in Nursing guidelines with minor additions or changes.

**There may be more stringent requirements for clinical agencies that may preclude the student’s progression in the nursing program. (revised 2/2005)

I have read the above Core Performance Standards & Criteria of Admission and Progression and hereby represent that I can effectively and safely perform the competencies listed.

Student Signature/Date: ________________________________

I attest that the information stated in this Health Record Packet is correct. Any false information may result in cancellation in my admission to the College.

Student Signature/Date: ________________________________
**Clinical Evaluation** (To be completed by the Physician) Date:________

Student Name:___________________________________________  DOB:_________________
Height:__________________  Weight:__________________  B/P:________________________
Use of Corrective Lenses:  (Y/N) __________________________________________________

**Laboratory tests required:**

1. Urinalysis:  Protein________  S.P. Gr.________  Glucose________  Acetone________
2. CBC_______  Hgb_______  Hct_______  WBC_______  RBC_______  Platelets_______
3. Rubella titer ____________ (required – attach results)
4. Varicella titer ____________ (required – attach results)

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Examination</th>
<th>Details</th>
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<tbody>
<tr>
<td>Head, neck, face, scalp</td>
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<tr>
<td>Nose and Sinuses</td>
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<td>Mouth and Throat</td>
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<tr>
<td>Teeth and Gingiva</td>
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<td>Ears: canals, tympanic membrane, etc.</td>
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<tr>
<td>Eyes (lids, conjunctiva)</td>
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<tr>
<td>Visual acuity.</td>
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<tr>
<td>Pupils and Ocular Motion</td>
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<tr>
<td>Lungs, chest and breast</td>
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<tr>
<td>Heart</td>
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<tr>
<td>Peripheral Vascular System</td>
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<tr>
<td>Abdomen and Viscera</td>
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<tr>
<td>Ano-Rectal and Philonidal</td>
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<tr>
<td>Endocrine System</td>
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<td>G-U System:</td>
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<td>• Pap smear</td>
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<td>• Testicular exam</td>
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<tr>
<td>• Bi-manual breast exam</td>
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<tr>
<td>Hands, Upper extremities</td>
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<tr>
<td>Feet, Lower extremities</td>
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<tr>
<td>Spine, Musco-Skeletal, Posture, mobility, fine motor skills</td>
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<tr>
<td>Skin and Lymphatic</td>
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<tr>
<td>Neurological Status</td>
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<tr>
<td>Mental/Emotional Status</td>
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According to my assessment, the above student is cleared to attend SFMC CON.

Physician Name (print):____________________________Phone:________________________

Physician Address (City, State, Zip):___________________________________________

Physician Signature: __________________________ ___Date:__________________
Immunization Documentation
(To be completed by Physician or Healthcare Provider)

Evidence and appropriate documentation from a Physician or Healthcare Provider is required in regards to updated immunizations, a physician diagnosed disease, or laboratory data.

Tetanus/Diphtheria (DT):
- DT must be current within the past (10) years.
- Tetanus toxoid (Tt) is not acceptable.
- Students born outside of the United States must provide a minimum of (3) doses (DPT/Td) with at least (1) dose within the past (10) years or re-immunize.

Measles/Mumps/Rubella (MMR):
- If you were born after 1/1/1968, you will need proof of 2 MMR immunizations with doses being at least 30 days apart AND a recent Rubella titer.
  MMR #1_____________ MMR #2_____________ Rubella titer_____________
- If you were born prior to 1/1/1968 and do NOT have the immunizations, titers of immunity are required:  Measles_________ Mumps_________ Rubella_________  
  (Attach proof regarding immunity)

Hepatitis B:
Due to direct patient contact, the Hepatitis B series is expected. **If the series is more than 10 years old, a titer is required.**
- Series Dates: #1_____________ #2_____________ #3_____________
- AntiHbS titer:_____________

Chicken Pox:
Due to direct patient contact in the areas of high risk health conditions, the Varicella titer is expected. If indicated by negative immunity, the vaccine will be administered 4 to 8 weeks apart.
- Date of disease_____________ AND Varicella titer_____________ OR
- Vaccines #1________ #2________ AND Varicella titer_____________  
  (Attach proof regarding immunity)

TB Testing:
Proof of (2) step within the past year:
(1) Step TB: Date_______________________ (2) Step TB: Date_______________________
  Site________________________ Site________________________
  Signature_____________________ Signature_______________________
  Induration____________________ Induration____________________
  Signature_____________________ Signature_______________________

Healthcare Provider Information for Immunization Documentation

Provider name (print):_________________________ Phone:_________________________

Provider address (city, state, zip):_________________________

Signature:_________________________ Date:_________________________