

All Health Records will be submitted through the Immunization Tracker.
Please see the attached form for directions.

Saint Francis Medical Center College of Nursing
511 N. E. Greenleaf Street, Peoria, IL 61603



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.)..... (Y/N)
2. Serious reactions to insect bites or food?..... (Y/N)
3. Infectious Mononucleosis?..... (Y/N)
4. Chicken Pox?..... (Y/N)
5. Hepatitis? What type?..... (Y/N)
6. High Blood Pressure?..... (Y/N)
7. Heart Murmur? Other cardiac disorders?..... (Y/N)
8. Diabetes, thyroid or other endocrine disorders?..... (Y/N)
9. Asthma? Bronchitis?..... (Y/N)
10. Colitis, abdominal pain, gastric disorders?..... (Y/N)
11. Shingles?..... (Y/N)
12. Kidney Stone? Kidney disorders?..... (Y/N)
13. Anemia? Blood disorders?..... (Y/N)
14. Back pain, disorders of the bone, muscle or joint?..... (Y/N)
15. Frequent or severe headaches or migraines?..... (Y/N)
16. Seizure disorder, convulsions, past head injury or concussions?..... (Y/N)
17. Disabling loss of vision?..... (Y/N)
18. Do you take medication (prescribed and/or over the counter) on a regular basis? If so, please list below..... (Y/N)
19. Have you had any serious dietary problems?..... (Y/N)
20. Any operations, hospitalizations or serious injuries? Please specify..... (Y/N)

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.

Issue	Standard	Some Examples of Necessary Activities (not all inclusive)
Critical Thinking	Patient Client needs/Problem Solving/Critical Thinking ability sufficient for clinical judgment. Use verbal, nonverbal cues to identify patient/client needs/problems.	Identify cause-effect relationships in clinical situations. Develop nursing care plan. Make judgment regarding appropriate interventions based on signs and symptoms.
Interpersonal	Interpersonal abilities sufficient to interact with individuals, families and groups from a variety of social, emotional, economic, religious, cultural, and intellectual backgrounds.	Establish rapport with patients/clients and colleagues and other health care providers.
Communication	Communication proficiency at a competent level in English, both verbal and written, to include reading, writing, spelling, speaking and listening.	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.
Mobility	Physical abilities sufficient to provide safe and effective nursing care.	Work in a standing position with frequent walking most of an eight-hour day; bend & stoop, push & pull objects such as a wheelchair, cart, gurney or equipment; lift & transfer clients from a stooped to an upright position.
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective nursing care.	Calibrate and use equipment; administer medications; position patients/clients.
Hearing	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.	Hear & respond to verbal communication and requests; respond to emergency signals, auscultatory sounds, percussion and auscultation, and hear cries for help.
Visual	Visual ability sufficient for observation, assessment and provision of nursing care.	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.
Tactile	Tactile ability sufficient for observation, assessment and provision of nursing care.	Perform palpation and other functions of physical examination or those related to therapeutic intervention, e.g., insertion of a catheter.
Other	Mental alertness sufficient to provide safe, effective nursing care.	Observe and respond to patient/clients and provide therapeutic interventions accurately and safely.

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) |

Normal	Abnormal	Examination	Details
		Head, neck face, scalp	
		Nose and Sinuses	
		Mouth and Throat	
		Teeth and Gingiva	
		Ears: canals, tympanic membrane, etc.	
		Eyes (lids, conjunctiva) Visual acuity.	
		Pupils and Ocular Motion	
		Lungs, chest and breast	
		Heart	
		Peripheral Vascular System	
		Abdomen and Viscera	
		Ano-Rectal and Philonidal	
		Endocrine System	
		G-U System: <ul style="list-style-type: none"> • Pap smear • Testicular exam • Bi-manual breast exam 	
		Hands, Upper extremities	
		Feet, Lower extremities	
		Spine, Musco-Skeletal, Posture, mobility, fine motor skills	
		Skin and Lymphatic	
		Neurological Status	
		Mental/Emotional Status	

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:** _____ 