LAKEVIEW COLLEGE OF NURSING

MANDATORY STUDENT IMMUNIZATION & COMPLIANCE DOCUMENTATION FORM

This is the only form accepted by Lakeview College of Nursing

PLEASE PRINT:

Last Name First Name Middle Name E-mail Address

SEASONAL FLU VACCINATION *(Attach documentation)*

Required annually, **every October**. Date _____

TETANUS, DIPHTHERIA & PERTUSSIS

TdaP required. (Tetanus Toxoid (TT) not acceptable).

☐ Last Booster Shot – Date _____

Booster must be within the last 10 years.

HEPATITIS B Surface antibody titer (*Attach copy of lab report)*

☐ **Immunity confirmed by titer. Date of Titer** _____

HB surface antibody ☐ Positive ☐ Negative

If non-immune to Hep B, series of immunizations must be started or a declination waiver must be signed. You can obtain waiver from Lakeview College of Nursing. You must submit documentation of each shot as you receive.

*If antibody test is negative repeat immunization series is **highly recommended**.*

MEASLES, MUMPS & RUBELLA ***(Titer Required for Each Condition)***

MEASLES (RUBEOLA) (*Attach copy of lab report)*

☐ Immunity confirmed by titer (IgG). Date of Titer _____

MUMPS (*Attach copy of lab report)*

☐ Immunity confirmed by titer (IgG). Date of Titer _____

GERMAN MEASLES (RUBELLA) (Attach copy of lab report)

☐ Immunity confirmed by titer (IgG). Date of Titer _____

Titers determined to be nonimmune will require two boosters of MMR 4 weeks apart followed by a titer 4-6 weeks after second booster shot. You must submit documentation of each booster and second titer.

OTHER REQUIREMENTS:

☐ **DRUG SCREEN 10 Panel** *(Attach copy of lab report).*

Drug screening must be done within 3 months from date of admission into Lakeview College of Nursing.

☐ **CPR CERTIFICATION**

Evidence of current American Heart Association-BLS Healthcare Providers or American Red Cross CPR/AED for Professional Rescuer is required for registration in all clinical nursing courses. The course must be specified for health care professionals. Include copy of card (front & back).

☐ **CURRENT IMMUNOSUPPRESSIVE MEDICATIONS**

Explain: _____

MENINGOCOCCAL VACCINE - Required.

☐ Immunization – Date _____

Vaccine must be on or after your 16th birthday.

VARICELLA ZOSTER (CHICKEN POX) *(Attach lab report)*

☐ Immunity confirmed by titer (IgG). **TITER IS REQUIRED**

Date of Titer _____ Result _____

Titers determined to be nonimmune will require two boosters of Varicella vaccine 4 weeks apart followed by a titer 4-6 weeks after second booster shot. You must submit documentation of each booster and titer.

TUBERCULOSIS *(Attach documentation)*

☐ HAS HAD THE DISEASE ☐ HAS NOT HAD THE DISEASE

☐ QTBG Quantiferon-Gold Blood Test - ***Required***

Date _____ Results _____

☐ Had a positive TB test. When? _____ Year.

Include documentation results and copy of chest x-ray report.

Baseline chest X-ray-Date _____ ☐ Positive ☐ Negative

Complete annual TB questionnaire, found in Registrar's office.

CERTIFICATION by Health Care Professional

Name, Address, Phone & Fax of Health Care Provider Completing Form and Institution or Clinic Where Provided (or stamp)

I certify that this information is complete and correct to the best of my knowledge.

_____ _____

Signature of Health Care Provider **Date**

HEALTH RECORD DUE DATES:

Fall: July 1st Spring: December 1st

***Students who fail to submit the completed admission health records/immunizations by the specified due date will be dropped from all clinical courses.**

N210, N301,N303, N305, N308, N310, N403, N404, N405 & N408

HEALTH HISTORY **ONLY SECTION TO BE COMPLETED BY STUDENT**

ALLERGIES (Food, drug, insect, latex, other)			**MEDICATION** (List all prescribed or taken on a regular basis.) **HCP Statement Required.**		
Diagnosis of asthma?	Yes No	**Indicate Severity**	Eye/Vision problems? _____ ☐ Glasses ☐ Contacts	Yes No	**Indicate Severity**
Birth defects?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Ear/Hearing problems?	Yes No	
Diabetes?	Yes No		Bone/Joint problem/Injury/Scoliosis?	Yes No	
Head injury/Concussion/Passed out?	Yes No		Loss of function of one of paired organs? (eye,/ear/kidney)	Yes No	
Seizures? What are they like?	Yes No		Hospitalizations? When? What for?	Yes No	
Heart problem?	Yes No		Surgery? (list all) When? What for?	Yes No	
High blood pressure?	Yes No		Serious injury or illness?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Foot/Back Problems	Yes No	

Other concerns or comments on any yes answers? If needed, provide additional information on another sheet of paper.

Information may be shared with appropriate personnel for health and educational purposes.

Student Signature: **Date:**

ENTIRE SECTION BELOW TO BE COMPLETED BY MD/DO/APN/PA

Physical examination requirements **Height** **Weight** **Blood Pressure**

System Review	**Normal**	**Comments/Follow-up/Needs**	**System Review**	**Normal**	**Comments/Follow-up/Needs**
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes			Genito-Urinary		
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Examination		
Cardiovascular/HTN			Nutritional Status		
Respiratory			Mental Health		

EMERGENCY ACTION e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem Yes ☐ No ☐ If yes, please describe.

Physician/Health Care Provider Signature_____ Telephone_____ Date_____

Please Print: Physician's/Health Provider's Name_____ Address_____

I hereby give my permission to release any and all information contained in this record to the appropriate health officials as may be required by the Illinois Department of Public Health and/or the clinical facility at which I will be assigned for education. I also understand that I am responsible for the integrity of my student health record.

STUDENT SIGNATURE_____ DATE_____

Form Revised on 8-17-2017

LAKEVIEW COLLEGE OF NURSING
Health Record Requirements

December 1st – Spring Admissions July 1st – Fall Admissions

You will be dropped from all clinical courses if not submitted by deadline.
Please make yourself a copy of all health records you send in.
(There is a $5 fee for any copies made by Lakeview after you submit them)

☐	**Current Physical Examination** **Must be within last year** (To rule out infections or contagious disease)
☐	**Meningococcal Vaccine** Proof of at least one dose of meningococcal vaccine on or after your 16th birthday.
☐	**Tetanus Booster (Tdap)** Current within the last 10 years.
☐	**Hepatitis B Surface Antibody Titer** Titer is required. If you are non-immune, series of immunizations (injection on a 0-, 1-, and 6-month schedule) must be started or a declination waiver signed. You may request waiver at agrant@lakeviewcol.edu. Titer must be done before waiver can be signed. – Include lab report
☐	**Influenza Vaccine** Those who have severe allergies to chicken eggs or those who have Guillain-Barre syndrome (obtained after a flu vaccine) should not receive a flu vaccine. For those who decline to get a vaccine due to a medical contraindication or religious belief, they will be required to fill out a waiver form and MUST wear a mask during the flu season while attending all clinicals. *If you are starting the nursing program in January you must get the flu shot now. If you are starting in August you will need to get your flu shot by October 25th.
☐	**Varicella Titer** Required even if you have been vaccinated or had the disease in the past. (Those determined to be non-immune, will require 2 doses of Varicella vaccine, then another titer to prove immunity) – Include lab report
☐	**MMR Titer** A titer for Measles, Mumps and Rubella are required even if you have been vaccinated in the past. (Those determined to be non-immune, will require 2 doses MMR vaccine, then another titer to prove immunity) – Include Lab report
☐	**TB Quantiferon** If you test or have tested positive for TB, you will need a chest x-ray within the last 10 years, along with a yearly symptom update.
☐	**10 Panel Urine Drug Screen –** Must be dated within 3 months from date of admission. Need to show proof of an itemized list of drugs tested for along with results for each.
☐	**Current CPR Card –** Only 2 courses accepted are: The American Heart Association-BLS Healthcare Provider –OR– The American Red Cross-CPR/AED for Professional Rescuers and Health Care Providers.
☐	**Hepatitis A** Highly recommended due to the high at-risk population and occupation (CDC, 2011), but is not required.

Please mail, fax or e-mail copies of your health records to:

Lakeview College of Nursing
Attn: April Grant
903 N. Logan Avenue
Danville, IL 61832
Fax #: 217-709-0953
E-mail: agrant@lakeviewcol.edu