Bellarmine University Physical Therapy Program Student Health Record:

This 4-part form requires:

1. Health History: Completed by the student
2. Physical Exam: Completed by a physician and/or Advanced Registered Nurse Practitioner. Please note all sections must be completed.
3. Immunization certificate: Completed with a signature by a physician, nurse or a health department official. Both required and recommended immunizations are identified on the form. Additional documentation of proof of immunity may be required as indicated on the form.
4. Tuberculosis Screening: Completed with a signature by a physician, nurse or a health department official. *We will offer an opportunity for TB testing on campus for a nominal fee in the month of June that will meet this requirement for your first year.*

It is mandatory to adhere to health and immunization requirements. You will not be permitted to participate in clinical education activities unless the Student Health Record is complete. Please note that if a medical contraindication to immunization(s) is present, this needs to be documented by your primary healthcare provider. You will also be required to sign the appropriate waiver form(s) that acknowledge your exposure to and risk of acquiring said disease. Please know that placement in clinical sites cannot be guaranteed without compliance to all immunization requirements. Any questions should be directed to the Director of Clinical Education. Waiver forms are available if needed.

Updates to the Student Health Record, including subsequent physical exams and TB screenings, are required annually.

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BELLARMINE UNIVERSITY
Physical Therapy Program

STUDENT HEALTH RECORD

PART I. Health History *(To be completed by the Student)*

A. Biographical Information

Student ID Number: _____

Name: _____ Email: _____@bellarmine.edu

Address *(local)*: _____
Street (Apt.) City State ZIP

Address *(permanent)*: _____
Street (Apt.) City State ZIP

Phone *(local)*: _____ Phone *(permanent)*: _____ Phone *(cell)*: _____

Gender: _____ Race/Ethnic Origin: _____ Marital Status: _____ Children *(how many)*: _____

B. Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Address: _____ Alt.Phone: _____

C. Health Insurance Information

All of the following information is REQUIRED; clinical sites may require you to show additional proof of insurance coverage (card).

Health Insurance Company: _____ Policy Holder: _____

ID/Policy Number: _____ Group Number: _____ Phone: _____

Address: _____

D. Present and Past Health Status *For asterisked items, if none, please state none.*

*Allergies: _____

*Medications Prescribed: _____

Over-the Counter: _____

*Previous Surgeries: _____

* Chronic Illness/Problems: _____

* Restrictions or Limitations on Function: _____

Check if you have a history of the following. Indicate the year when experienced or diagnosed:

☐ Asthma: _____	☐ Headaches: _____	☐ Mononucleosis: _____
☐ Cancer: _____	☐ Hearing Disorders: _____	☐ Muscular Disorder: _____
☐ Diabetes: _____	☐ Heart Disease: _____	☐ Rheumatic Fever: _____
☐ Epilepsy: _____	☐ Hepatitis: _____	☐ Skeletal/Joint Disorders: _____
☐ Emotional Disorders: _____	☐ Lung Disorders: _____	☐ Visual Disorders: _____

☐ Other (Specify): _____

I attest that the information in this Student Health Record is accurate to the best of my knowledge. I understand that I will not be allowed to participate in clinical experiences if the health record is incomplete and/or all immunizations are not properly documented. I also understand that all health-related information will be treated confidentially by the program and it will be my responsibility to release any health-related information to the clinical site upon request.

Student's Signature: _____ **Date:** _____

PART II. Physical Examination *(To be completed by a Physician or Advanced Registered Nurse Practitioner)*

Student Name: _____

Date of Birth: _____ **Height:** _____ **Weight:** _____ **Pulse:** _____ **Blood Pressure:** _____

Vision: R 20/_____ L 20/_____ Corrected: ☐ Yes ☐ No Color Vision Screening ☐ Normal ☐ Abnormal

Auditory: ☐ Normal ☐ Abnormal

Urinalysis: ☐ Normal ☐ Abnormal

Hemoglobin & Hematocrit: ☐ Normal ☐ Abnormal

	NORMAL	**ABNORMAL**
Skin/Hair/Nails		
Head		
Ears/Nose/Throat		
Neck		
Chest and Lungs		
Heart and Peripheral Vascular		
Breasts		
Abdomen		
Genitalia		
Rectum		
Musculoskeletal		
Neurological		

Limitation of Activity: _____

Is there any medical health condition that would hinder progress through a physical therapy program?

☐ Yes. If so, please explain: _____

☐ No

_____ _____
Examiner's Signature Date of Examination

_____ _____
Examiner's Name (print) Examiner's Title

Examiner's Address: _____
Street (Suite) City State ZIP

Examiner's Telephone: _____

PART III. Immunization Record *(To be completed by a Physician, Nurse, or Health Department Official)*

Immunity requirements are identified below. Please indicate dates administered (month/day/year) and attach lab results where indicated. An immunization certificate issued and signed by the healthcare provider may also be used to document immunizations if documentation includes all below components. If there is medical contraindication to any required immunization(s), verification from the primary provider must accompany this health record. When any medical contraindication exists, a waiver must be signed by the student to acknowledge that inadvertent exposure might occur and to release the clinical site and university from liability in the event of exposure. Appropriate waiver form(s), obtained from the program, must be signed and on file in the Physical Therapy Department.

IMMUNIZATION CERTIFICATE

Student Name: _____ **Date of Birth:** _____
(First) (Middle) (Last)

Does student report having taken the DPT series as a child? ☐Yes ☐No Polio series as a child? ☐Yes ☐No

TETANUS, DIPHTHERIA, and PERTUSSIS Student must receive a 1-time dose of Tdap, regardless of interval from last Td. After receipt of Tdap, a routine booster of Td is required every 10 years. Minimum requirement: Tdap within 10 years **or** if Tdap >10 years then Td booster within 10 years.
Tetanus /Diphtheria / Pertussis (Tdap)*: ____/____/____ Tetanus / Diphtheria (Td) : ____/____/____

MEASLES, MUMPS, and RUBELLA (MMR) Student must receive two doses of MMR vaccine separated by 28 days or more **or** have serologic immunity to measles, mumps, and rubella.
MMR Dose #1 ____/____/____ Dose #2 ____/____/____ **OR**
Date of Measles titer ____/____/____ *Lab result must be attached. **Immune** ☐Yes ☐No
Date of Mumps titer ____/____/____ *Lab result must be attached. **Immune** ☐Yes ☐No
Date of Rubella titer ____/____/____ *Lab result must be attached. **Immune** ☐Yes ☐No

HEPATITIS B Student must receive 3-dose series of hepatitis B vaccine at 0-, 1-, and 6-month intervals. Serologic immunity is recommended to be tested 1-2 months after completion of the three dose hepatitis B vaccine series. Anti-HBs testing is not recommended routinely for previously vaccinated individuals who were not tested 1–2 months after their original vaccine series; however, testing for anti-HBs should occur after an exposure to blood or body fluids.
Hepatitis B Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____
Date of Hep B Surface Antibody ____/____/____ *Lab result must be attached. **Immune** ☐Yes ☐No

VARICELLA Student must receive two doses of varicella vaccine **or** have serologic immunity
Dose #1 ____/____/____ Dose #2 ____/____/____ **OR** Date of Varicella IgG Antibody titer ____/____/____
*Lab result must be attached. **Immune** ☐Yes ☐No

INFLUENZA Student is required to receive an influenza vaccine annually in the fall of the year. (No later than December 1)
Year #1 ____/____/____ Year #2 ____/____/____ Year #3 ____/____/____

I CERTIFY THAT THE ABOVE NAMED STUDENT HAS RECEIVED IMMUNIZATIONS AS NOTED ABOVE.

_____ _____
SIGNATURE of Physician, Health Care Provider, or designee **Date**

Office or Healthcare Provider Stamp:

PART IV. TB Skin Testing *(To be completed by a Physician, Nurse, or Health Department Official)*

All students are required to have an **annual** tuberculin skin test (PPD). Please complete as indicated or attach comparable documentation or screening certificate signed by the healthcare provider. Some clinical sites require two-step testing and/or testing within a six month period. Two-step testing is optional prior to clinical assignment.

TUBERCULOSIS SCREENING

TWO-STEP: 2nd skin test is to be completed 7 to 21 days from first skin test

1st Baseline skin test placed: ____/____/____ Baseline skin test read: ____/____/____ Results in millimeters: ____ mm

2nd skin test placed: ____/____/____ Baseline skin test read: ____/____/____ Results in millimeters: _____ mm

OR Blood Draw test: (circle one) T-SPOT® TB or QuantiFERON®–TB Gold test Date: ____/____/____

Results: _____ *Lab result must be attached.

If test is positive, a copy of your chest x-ray report evidencing no active disease must be attached.

Prophylactic treatment for positive PPD: ☐Yes ☐No

Treated with: _____ x _____ months.

Completed treatment date: ____/____/____

_____ _____

SIGNATURE of Physician, Health Care Provider, or designee **Date**

Office or Healthcare Provider Stamp: