SAM HOUSTON STATE UNIVERSITY
A Member of The Texas State University System

SCHOOL OF NURSING
1 Financial Plaza, Suite 215
Huntsville, TX 77340
936.294.2371 • FAX 936.294.2372

HEALTH CERTIFICATE

The student must make an appointment with his/her healthcare provider to document:

All immunizations are completed including date of booster. (Notes: See Immunizations and Tests Form. Clinical affiliations may require additional immunizations and/or tests.)

Student is in good physical health and free from diseases listed on the Immunizations and Tests Form.

Completed Health Certificate and Immunizations and Tests Form (5 pages) must be submitted no later than two weeks from the date of the initial welcome email from SHSU School of Nursing.

Information on this form is confidential.

Date:		
Student Name:	SAM ID:	DOB (mm/dd/yyyy):
Address:	City, State, ZIP:	
Best Contact Number(s):	Email (SHSU):	

Person to Notify in Case of Emergency

Name:		Relationship:
Address:	City, State, ZIP:	
Best Contact Number(s):		

Health Insurance Information

All nursing students are required to carry, maintain, and show proof of health insurance while in SHSU's Nursing Program. Please attach a copy of your health insurance card.

Name of Insurance Company:	Policy #:
Subscriber's Name:	

From the SHSU Nursing Student Handbook (page 13):

"NOTE: ALL STUDENTS IN THE SCHOOL OF NURSING ARE RESPONSIBLE FOR HEALTH CARE COSTS ASSOCIATED WITH ANY COURSE-RELATED INJURY OR ILLNESS THEY SUSTAIN WHILE ENROLLED IN NURSING COURSES."

Health Questionnaire

To be completed by the student:

Have you been diagnosed or under the care of a healthcare provider for any of the following? If YES, please specify.

CONDITION	YES	NO	CONDITION	YES	NO
Hearing Problem	❑	❑	Depression	❑	❑
High Blood Pressure	❑	❑	Worry or Nervousness	❑	❑
Heart Problem	❑	❑	Allergy/Hay Fever	❑	❑
Rheumatic Fever	❑	❑	Respiratory Disorder	❑	❑
Diabetes	❑	❑	Skin Disorders	❑	❑
Thyroid Disorder	❑	❑	Tuberculosis or Treatment to Prevent	❑	❑
Anemia	❑	❑	Cancer, Cysts, Tumor, etc.	❑	❑
Seizure Disorder	❑	❑	Intestine or Stomach Problems	❑	❑
Headaches	❑	❑	Urinary Infection	❑	❑
Dizziness/Fainting	❑	❑	Drug or Alcohol Abuse	❑	❑

YES	NO	
❑	❑	Do you have any drug allergies? Specify:
❑	❑	Do you have any allergies to insect stings, foods, latex, or others? Specify:
❑	❑	Do you have hypoglycemia (low blood sugar)?
❑	❑	Do you have any loss of paired-organ function (eye, kidney, testicle)?
❑	❑	Have you ever fainted (syncope) or nearly fainted? If YES, please explain:
❑	❑	Have you had a serious illness in the past? If YES, please explain:
❑	❑	Have you ever had any operations? If YES, please list:
❑	❑	Have you been hospitalized in the past five (5) years? If YES, please explain:
❑	❑	Are you currently being treated for any chronic condition? If YES, please explain:
❑	❑	Do you have any physical limitations that would affect your ability to lift, turn, or transfer patients?
❑	❑	Do you have any limitations in use of your senses, such as sight or hearing, which would limit your ability to practice a health profession?
❑	❑	Do you have any other condition which might interfere with your ability to practice in the health profession?

If you answered YES to any of these questions, please explain your limitations in detail in the space provided below each question or on a separate sheet of paper.

List any medications – prescribed or over the counter – you take on a regular or frequent basis this year. (This information is not required but will assist SHSU's Nursing Program in having your accurate health history.)

*To be completed by your **health provider**:*

Name:_____ Date of Physical:_____

Height:_____ Weight:_____ BP:_____ P:_____ T:_____ R:_____ BMI:_____

Vision: L_____ R_____

Physical Exam

✓ (check) = Normal ○ (circle) = N/A Blank = Not Examined

		Additional Findings
❑	General: Healthy appearing; in no acute distress.	
❑	Skin: Warm, pink, dry with no rash or lesions.	
❑	Head/Face: Normcephalic. Normal hair growth.	
❑	Eye: Sclera white. PERRLA.	
❑	Nose/Sinuses: Sinuses nontender to palpation, nares patent.	
❑	Ears: No pain when helix pulled. External canal normal. TM with light reflex and landmarks present without erythema, injection, bulging, fluid, retraction, perforation, or drainage. No hearing loss.	
❑	Pharynx: Good dental hygiene. No tonsillar hypertrophy. No erythema, swelling, injection, exudates, or lesions of palate/pharynx. Uvula midline.	
❑	Neck: Supple with full ROM. No cervical adenopathy. No thyromegaly.	
❑	Respiratory: Respirations easy and non-labored. Aerates all lobes well. Lungs clear to auscultation and percussion. No pleural rub heard.	
❑	Cardiovascular: Regular S1, S2 without murmur, gallop, or rub. No peripheral edema.	
❑	Abdomen: Soft, nondistended with active bowel sounds x 4. No hepatosplenomegaly. No abdominal guarding, rigidity, tenderness, or masses on palpation. No CVA tenderness.	
❑	Musculoskeletal: Extremities with full ROM, no varicosities.	
❑	Neurologic: Oriented x 3. Cranial nerves II-XII intact.	
❑	Breast: Symmetrical, no masses/lumps, no dimpling, no palpable nodes, no nipple discharge, no retraction, no tenderness, BSE discussed.	
❑	Genitourinary: External genitalia and hair distribution WNL, inguinal nodes WNL. No hernias noted (male).	

RECOMMENDATIONS:		
YES	NO	Based upon your physical examination, is the applicant free of any restrictions in his/her ability to turn or move heavy objects? If "NO," describe:
YES	NO	Is the applicant able to see and hear adequately to practice a health care profession? If "NO," please explain:
YES	NO	Is the applicant free of any pathological conditions, either physical or mental, that would interfere with the practice of a health profession? If "NO," please describe:

Signature of Health Care Provider (physician, NP, PA):	Date:
Printed Name/Stamp of Health Care Provider (physician, NP, PA):	
Address:	
Additional Comments:	

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IMMUNIZATIONS AND TESTS FORM

Required by State Law and Clinical Facilities

Student's Name: _____ **SAM ID:** _____ **Date of Birth:** _____

PHYSICIAN OR OTHER HEALTH CARE PROVIDER VERIFICATION – To be completed by the Health Care Provider:

MMR

Two doses of Measles/Mumps/Rubella (MMR) vaccine at least 30 days apart

1st Immunization Date: _____

2nd Immunization Date: _____

OR

Measles IgG Titer:*	*Mumps IgG Titer*:*	*Rubella IgG Titer*:*
✦**Serologic Test (Date):** _____	✦**Serologic Test (Date):** _____	✦**Serologic Test (Date):** _____
✦**Serologic Test (Result):** _____	✦**Serologic Test (Result):** _____	✦**Serologic Test (Result):** _____

(*Copy of lab results with reference ranges must be attached)

Hepatitis B

Three doses of vaccine administered over a period of four to six months; initial vaccine followed by one and four to six months vaccines, respectively

1st Immunization Date: _____
and
2nd Immunization Date: _____
and
3rd Immunization Date: _____

OR

Hepatitis B Surface Antibody*:
✦**Serologic Test (Date):** _____
✦**Serologic Test (Result):**

(*Copy of lab results with reference ranges must be attached)

Varicella

Two doses of varicella vaccine administered four to six weeks apart

1st Immunization Date: _____
and
2nd Immunization Date: _____

OR

Varicella IgG Titer*:
✦**Serologic Test (Date):** _____
✦**Serologic Test (Result):** _____

Tdap

Must have Tdap **AS AN ADULT** within past 10 years

Immunization Date: _____

INFLUENZA

Immunization Date: _____

Meningitis Vaccine

Immunization Date: _____

The vaccination is required every five years of all college students as of January 1, 2012. (Senate Bill 1107). Students >22 years of age are not required to obtain this vaccination.

Tuberculosis (skin test within 12 months **OR** chest x-ray)

Date placed: _____

Date Read: _____ **Result (in mm):** _____

(If positive result, results of a current chest x-ray will be required)

Date of chest x-ray: _____ **Result of x-ray:** _____

(Copy of chest x-ray report must be attached)

Physician or Approved Licensed Health Professional Information
(Primary Care Provider signature validates all above information)

Printed Name:

Address:

Signature of Primary Care Provider: Date:

✦**Must be the date of test collection, not when primary care provider signed immunization form.**
***Copy of lab results with reference ranges must be attached.**
Vaccines administered shall include the mm/dd/yyyy each vaccine was given.

Revised 4/22/16