Dear Applicant:

Enclosed are the required health forms that must be completed. Upon receipt of this form have your doctor start vaccinations at once. To be protected and in compliance with the Illinois Department of Public Health, please note the following:

- All listed immunizations are required.
- Day, month, and year dates on which immunizations were given are important.
- Students must have received 3 or more doses of (DTP) or (TD) vaccine, administered at the appropriate age, and the last dose having been received within 10 years of enrollment.
- Students must have received two doses of live measles vaccine (Rubella and Rubeola), with the first dose administered not earlier than 12 months of age and the second dose no less than one month later, or had physician diagnosed measles disease, or have laboratory evidence of immunity by a detectable antibody titer.
- Students must have received mumps vaccine not earlier than 12 months of age. Record of receiving the MMR vaccine, physician verified disease by office record, or adequate titer showing immunity is acceptable.
- Two-step TB skin testing – Mantoux Test requires two intradermal injections 7-21 days apart with a reading within 48-72 hours of each injection. Results must be recorded in millimeters with the date given and the date read for each injection.

ATTENTION: All Immunizations must be complete by the first day of class. It is advised that you make copies of all immunization records for your personal use and always keep one set for your future use.

Any immunizations, except Varicella, not updated/verified before clinical may be administered through Occupational Health Service (a bill will be sent to the student for each immunization and/or titer). A student charge list for immunizations and testing through OSF Occupational Health Services is available upon request. **NO STUDENT MAY ATTEND A CLINICAL COURSE IF IMMUNIZATIONS ARE NOT UP-TO-DATE!**

If you have any questions or concerns, please the Graduate Affairs Department at 815-395-5476 or the Occupational Health Department at OSF Saint Anthony Medical Center at 815-395-5354.

Saint Anthony College of Nursing
Rockford, Illinois
IMMUNIZATION RECORD

In accordance with Illinois Department of Public Health regulations, proof of immunity against preventable communicable disease is required prior to registration. This record must be completed by your health care provider.

Name_____D.O.B._____Phone_____

Address_____
Street City State Zip

Term Attending – Fall or Spring - Year_____ Are you an OSF/SAMC employee?_____
(Please mark only Fall if MSN Student)

RELEASE AUTHORIZATIONS

_____I authorize and request my health care provider_____, to release the following medical records to Saint Anthony College of Nursing.

_____I authorize Saint Anthony College of Nursing to release this immunization record to the Illinois Department of Public Health or its designated representative for compliance audits and in the event of a health or safety emergency.

____I authorize Saint Anthony College of Nursing to release this immunization record to OSF Saint Anthony Medical Center Employee Health Department for compliance audits, in the event of a health or safety emergency, and for maintenance of my medical information.

Student Signature_____Date:_____

RECORD MUST BE COMPLETED BY HEALTH CARE PROVIDER

MONTH AND YEAR ARE REQUIRED

MEASLES (RUBEOLA) Students must have received two doses of live measles vaccine, with the first dose administered not earlier than 12 months of age and the second dose no less than one month later, had physician documented measles disease, or laboratory evidence of immunity by a detectable antibody titer. Immunity to rubeola must be documented prior to admission.	Dates immunized with live measles vaccine (Measles, M/R or MMR): Date disease confirmed by office record: Date and lab results of immunity evidenced by titer:	1_____ **M D Y** 2_____ **M D Y** M D Y _____ **M D Y** Results_____
MUMPS Mumps vaccine must be administered not earlier than 12 months of age. Physician diagnosed and documented case of disease is acceptable or adequate titer demonstrated by appropriate lab testing is acceptable as of Feb, 1993.	Dates immunized with mumps vaccine (Mumps or MMR): Date disease confirmed by office record: Date and results of immunity as evidenced by titer: Type of test_____	1_____ **M D Y** M D Y 2_____ **M D Y** M D Y _____ **M D Y** _____ **M D Y** Results_____

RUBELLA (GERMAN MEASLES) Rubella vaccine must not be administered earlier than 12 months of age. Laboratory evidence of immunity is acceptable. History of disease is not acceptable. Evidence of immunity must be documented prior to admission.	Date immunized with rubella vaccine (Rubella, MR or MMR): Date and results of immunity as evidenced by titer:	_____ M D Y _____ **M D Y** M D Y _____ **M D Y** Results_____

POLIO	Date and type of vaccine in primary series _____Oral (Sabin) _____Injection (Salk) Date of last booster _____Oral _____Injection	_____ M D Y _____ M D Y
TUBERCULOSIS A two step TB Mantoux skin test (PPD) is required. These tests must be given 7-21 days apart. Each test must be read 48-72 hours after administration. TB testing needs to be completed within 6 months of the clinical rotation. TB testing must be repeated if the student leaves the country between TB tests. (Chest x-ray, completed TB questionnaire, and clearance from the student's local health department are required for a positive PPD test. If the student took medication for the positive TB test, only the CXR in the last 12 months and TB questionnaire are required.)	Dates and results of PPD two step process this year Date and results of PPD in senior year: Date and results of x-ray if PPD was positive:	1_____ M D Y Results_____ 2_____ M D Y Results_____ _____ M D Y Results_____ _____ M D Y X-ray results_____
HEPATITIS B (Hepatitis B vaccine is available at Saint Anthony Medical Center).	Dates of completed vaccine series:	1_____ M D Y 2_____ M D Y 3_____ M D Y
VARICELLA (CHICKENPOX) Known history of having chickenpox verified by parent, grandparent, sibling or doctor **OR** Varicella vaccine (2 doses one month apart).	Date and result of immunity as evidenced by titer: **OR** Dates of completed vaccine series: Date disease verified:	_____ M D Y Results_____ 1_____ M D Y 2_____ M D Y _____ M D Y

HEALTH CARE PROVIDER

Name _____ Phone _____

Address _____

_____

Signature _____ Date _____

Additional Health Care Provider (if needed)

Name _____ Phone _____

Address _____

_____

Signature _____ Date _____

Saint Anthony College of Nursing

Rockford, Illinois

TO BE COMPLETED BY STUDENT
STUDENT HEALTH RECORD

Name_____ Birth date_____

Home Address_____

street city state zip

Medical History All medical information is strictly confidential. Please answer each question YES or NO and if the answer is yes, provide details on the line provided.	**YES**	**NO**
Allergic reactions to medicines? If yes, list medications and type of reaction:		
Serious reactions to insect bites or food? If yes, list the source and type of reaction:		
Allergy to latex? If yes, list type of reaction:		
Hay fever, hives, other allergies not previously mentioned? If yes, list source and type of reaction:		
Shingles? If yes, when did you have the shingles?		
Hepatitis? If yes, specify type of hepatitis:		
High blood pressure? If yes, what medications do you take for treatment?		
Heart Murmur, other disorders of the heart? If yes, specify type and treatment:		
Diabetes, thyroid, or other endocrine disorders? If yes, specify type and treatment:		
Asthma? Bronchitis? If yes, identify which and treatment:		
Colitis, chronic abdominal pain? If yes, specify which and treatment:		
Kidney stone, kidney disease? If yes, specify which and type of treatment:		
Anemia, other blood disorders? If yes, describe disorder and treatment:		
Back pain, other disorders of muscles, bones, joints? If yes, specify disorder and treatment:		
Frequent or severe headaches, migraine, head injury or concussion, convulsions? If yes, specify and date of last occurrence:		
Disabling loss of vision, hearing? If yes, specify and treatment or correction:		
Have you ever had serious dietary problems? If yes, specify and treatment:		
Any operations, hospitalizations, serious injuries? Specify type and date:		
Please record any medications you are taking that are not addressed above (prescription and over the counter):		