College of Health and Human Services
Governors State University SUCCESS BY DEGREES

GOVERNORS STATE UNIVERSITY
College of Health and Human Services

Nursing Program Student Health Form

This form is to be completed by a licensed health care provider (physician or nurse practitioner) and returned to the nursing program office prior to the first course in the nursing curriculum. Failure to return this form will result in an inability to begin course work.

_____ _____ _____
Last Name First Name MI

_____ _____
Date of Birth GSU Student Identification Number

Dear Health Care Provider:

The above-named student will soon be involved in clinical duties, which may expose him/her to potentially harmful infectious diseases. To assure that the student is adequately protected from harm, the following immunizations and tests should be administered and recorded. Please complete the following information and return it to the student. [***Note: A copy of the original lab report must accompany antibody titers***.]

Measles (Rubeola) Titer/Date _____/_____
or
Vaccine Administration Date_____

Rubella Titer/Date _____/_____
or
Vaccine Administration Date_____

Mumps Titer/Date _____/_____
or
Vaccine Administration Date_____

Varicella Titer/Date _____/_____
or
Vaccine Administration Date_____

Tetanus Date of Last Tetanus Booster _____

PPD Tuberculosis Skin Test

An initial 2-step TB skin test is required, with a 1-step TB skin test required annually.

Directions: The first step requires the student to receive a Mantoux Intradermal skin test, which is to be read within 72 hours. If negative, the second test is to be given 1-3 weeks later, and read within 72 hours.

Step 1
Date Given _____ Date Read_____ ❑ neg ❑ pos

Step 2
Date Given _____ Date Read_____ ❑ neg ❑ pos

Chest X-ray (if indicated) Date Given _____ Result_____
(attach copy of x-ray report)

Hepatitis B Vaccine

Dates of 3 injections: #1_____, #2_____, and #3_____
or
Date/Results of Serology* _____/_____
(*either HbsAb or HbcAb)

Physical Limitations ❑ No ❑ Yes Explain:_____
_____
_____
_____

Do you know of any disability, which would necessitate special assistance for the applicant to engage in clinical nursing behaviors? ❑ No ❑ Yes
Explain:_____
_____
_____

_____ _____ _____
Provider Signature (MD or Nurse Practitioner) Print Name & Credentials Date

_____ _(___)_____
Provider Address Telephone

I, _____hereby give my permission to the above-named provider to provide the
(Student Name)
requested health information to Governors State University nursing program.

_____ _____
Student Signature Date