

**DEPARTMENT OF NURSING
BEMIDJI STATE UNIVERSITY- STUDENT HEALTH DATA
(Required immediately upon entrance to the Nursing Major)**

Notice: Private Data – State and Federal Laws Limit Access. This form must be completed prior to beginning a practicum or lab experience.
PLEASE PRINT

NAME: _____	Phone#: (h) _____
(LAST) (FIRST) (M.I.)	Phone#: (w) _____
STUDENT ID #: _____ BIRTHDATE: _____	

I am providing the following information pursuant to Bemidji State University, Department of Nursing policy to assess eligibility to participate in clinical courses in the nursing program.

Please enter the month/day/year for **ALL** doses of **ALL** vaccines. Note the date/age if you have had a disease and/or the date/result of each antibody (blood test) done.

VACCINE	VACCINATION MO/DAY/YR			Had Disease? Yes/No Age/ Date	Antibody Titre (Blood Test) Required if no documented immunizations Results/Date
Hepatitis B	#1	#2	#3		
MMR (Measles, Mumps, Rubella Vaccine At least one dose required @ \geq 12 months of age	#1		#2		
Measles (Rubeola)					
Mumps					
Rubella (German Meales)					
TD - tetanus-diphtheria booster 1dose required within last 10 years					
Varicella - chicken pox Date/age of disease or 2 doses (at least one month apart) required	#1		#2		
Tuberculin Skin Test* (ppd – Mantoux)	____/____/____ Result: (circle one) Negative Positive mo day yr Provider signature If positive, date of last chest x-ray: _____ Provider signature				
*2-step Mantoux required if no Tb testing within the current one year period.	____/____/____ Result: (circle one) mo day yr Negative Positive Provider signature			____/____/____ Result: (circle one) mo day yr Negative Positive Provider signature	

I signify that the above information is accurate and complete to the best of my knowledge.

Student Signature: _____ **Date:** _____

Return to the nursing department office _____