LIBERTY UNIVERSITY RESPIRATORY THERAPY PROGRAM

Student Health Data Form

SECTION I (To be completed by student).

1. Name:_____
   Last First Middle Initial
2. Home Address:_____
   Street City State Zip
3. Local Address:_____
   Street City State Zip
4. Social Security Number:_____ 5. Date of Birth:_____
6. Home Phone: (___)_____ Local Phone: (___)_____
7. School e-mail:_____ Other e-mail:_____
8. Name and Telephone of Persons to be Notified in Case of Illness or Emergency:_____

Personal Health History: Have you had any of the following (circle "Yes" or "No")

High Blood Pressure	YES	NO	Boils	YES	NO	Red Measles	YES	NO
Anemia	YES	NO	Post HIV Antibod. Test	YES	NO	Mumps	YES	NO
Chicken Pox	YES	NO	Cancer/Tumors	YES	NO	Respiratory Problem	YES	NO
Back Problems	YES	NO	Kidney Problems	YES	NO	Hepatitis	YES	NO
Heart Problem	YES	NO	Alcohol/Drug Problems	YES	NO	Headaches	YES	NO
Tuberculosis	YES	NO	Epilepsy or Seizures	YES	NO	German Measles	YES	NO
Vision Problems	YES	NO	Mental/Nervous Condition	YES	NO	Ulcers	YES	NO
Diabetes	YES	NO	HIV/AIDS	YES	NO	Skin Rash	YES	NO
Hearing Loss	YES	NO	Arthritis	YES	NO	Surgeries	YES	NO

Please Explain any "YES" answers:_____

SECTION II (To be completed by a licensed health care provider.)

9. TB SCREEN (within last 12 months) Date of Test_____ Findings_____

	IMMUNIZATIONS:	**MONTH/DAY/YEAR**	**REQUIREMENTS**
10.	TETANUS	_____	A Booster within the last 10 years.
11.	MEASLES (MR or MMR)	_____	Students born on or after 1/1/57 must show proof of immunity to measles (physician validated HX or serologic confirmation).
12.	MUMPS (MMR)	_____	Students born on or after 1/1/57 must show proof of Mumps vaccination (physician validated HX or serologic confirmation).
13.	RUBELLA (MR or MMR)	_____	All students must show proof of vaccination or serologic confirmation.

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14. HEPATITIS B (HBV) **MONTH/DAY/YEAR**

All students are required to show proof of Hepatitis B Vaccine.

1st _____

2nd _____

3rd _____

Titre _____

Hepatitis B titer may be required after the series of immunizations is complete.

15. **RECOMMENDATIONS:**

Check one:

_____ No history or physical findings on this exam would prohibit this student from participating in patient care.

_____ This student should have the following health problems evaluated or treated before providing patient care. (Comments below.)

_____ This student has health problems that prohibit him or her from providing patient care. (Comments below)

Specific Comments: _____

_____

_____

Signature of Licensed Health Care Provider: _____

Signature Date

Provider's Name: _____

Print Name

Address: _____

Street

_____

City State Zip

Phone: (_____) _____

Please return this original form to:

John W. Lindsey
Department of Allied Health Professions – Respiratory Therapy Program
Center for Natural Sciences, T4