Dear Student,

Mount Carmel College of Nursing stipulates specific health requirements be documented prior to admission to the Undergraduate Program. Please have your health forms completed by a physician or nurse practitioner and submit to CastleBranch prior to the dates listed below. To create a CastleBranch account and place your order, go to http://portal.castlebranch.com/mp92

- For students starting Fall Semester—form must be received no later than July 30th
- For students starting Spring Semester—form must be received no later than December 15th
- For students starting Summer Semester—form must be received no later than April 15th

1. **History and Physical** – Signed by physician or APRN
2. **Tuberculin Skin Test:**
   - Two step PPD, which involves 2 skin tests, two weeks apart.
   - Chest x-ray report if positive skin test or previous history of Tuberculosis
3. **Measles, Mumps, Rubella Immunization:**
   - Two MMR vaccine dates
   - *OR dated results of:*
     - Measles Titer
     - Mumps Titer
     - Rubella Titer
     (Include a copy of lab result)
4. **Varicella Immunization: (Chicken Pox)**
   - Two Varicella vaccine dates (one month apart)
   - *OR dated results of:*
     - Varicella titer
     (Include a copy of lab result)
5. **Hepatitis B Immunization Series:**
   - Three Hepatitis B vaccine dates (complete or in process)
   - *AND dated results of:*
     - Hepatitis B titer
     (Include a copy of lab result, to be completed 4 weeks after series completed)
6. **Tetanus/Pertussis:**
   - A combination vaccine that includes tetanus and pertussis is required within the past ten years.
7. **Current Influenza Vaccine is required.**
8. **Meningitis Vaccine**
   - Required only if planning to live in the on-campus apartments

The Tuberculin skin test is repeated annually, one year after the initial "2-step," until completion of the program. Annual Influenza vaccines are required for all students at Mount Carmel College of Nursing.

If the health form and immunizations are not uploaded to CastleBranch by the stated deadline, a **$50.00 late fee** will be assessed to the student account **weekly** until the required documents are uploaded. Questions for CastleBranch can be addressed to https://www.castlebranch.com or 888-666-7788.

Feel free to call me at 614-234-5408 if you have any questions or concerns about your health requirements.

Respectfully,

Laura Lawrence, RN
MCCN Student Health Nurse
PERSONAL DATA:
Semester and Year of Admission ____________ BSN or Second Degree Program __________
If transfer student, indicate Fr, So, Jr, Sr ______________

This section is to be completed by the student. The information provided will be treated confidentially and will not be released without the student's consent. Please print or type information.

Name_____________________________________________________________________________

(Last) (First) (Middle) (Former Last Name)
Male _____  Female _____ Date of Birth _____ / _____ / ______ SSN ______- _____ - __________ 

Mo. Day Yr.

Address_____________________________________________________________________________

Street City State Zip Code

Email address ___________________ Cell Phone(____) ____ - _____ Home Phone(____) ____ - _____

Family Physician: ___________________________________________ Phone(____) ____ - _____ 

Who to notify in case of emergency _____________________________ Relationship________________

Telephone: __________________________________________________________________________ 

Home Cell Work

Student Signature __________________________________________ Date____________________

HEALTH CLEARANCE:
The examining physician or nurse practitioner must complete the following part of this form. The information provided will be treated confidentially and will not be released without the student's consent.

Tuberculin Skin Test: 1. date given:______________ date read:______________ results:__________ mm
2 date given:______________ date read:______________ results:__________ mm

- Two step PPD, which involves 2 skin tests, 2 weeks apart.
- Chest x-ray report if positive skin test or previous history of Tuberculosis

Measles, Mumps, Rubella Immunization:
- Two MMR vaccine dates 1._____________ 2._____________

OR dated results of:
- Measles Titer
- Mumps Titer
- Rubella Titer
  (Include a copy of lab result)

Hepatitis B Immunization Series:: (in process or complete)
- Three Hepatitis B vaccine dates 1._____________ 2._____________ 3._____________

AND dated results of:
- Hepatitis B titer
  (Include a copy of lab result, to be completed 4 weeks after series complete)

Varicella Immunization:
- Two Varicella vaccine dates 1._____________ 2._____________

OR dated results of:
- Varicella titer
  (Include a copy of lab result)

Tetanus/Pertussis (within past ten years) ____________________________

Annual Flu Vaccine ____________________________________________

Meningitis Vaccine (Required only if plan to live in the on-campus apartments) ________________
MOUNT CARMEL COLLEGE OF NURSING UNDERGRADUATE HEALTH FORM

. Student Name_________________________________ Date of Assessment________________

Last                           First                     Middle

HEALTH HISTORY:
The examining physician or nurse practitioner must complete the following part of this form. The information provided will be treated confidentially and will not be released without the student’s consent.

Please list and describe any pertinent medical history:

Allergies:

Medications currently taking routinely:

EXAMINATION: Height_________  Weight_________ Blood Pressure_________ Pulse_________

Is there, on examination, any abnormality of the following?

Sensory system

______________________________________________________________________________

Nervous system (includes gait, reflexes, paralysis, seizures)

____________________________________________________________________________________

Respiratory system

__________________________________________________________________________________

Cardiac system (murmur, dyspnea, edema)

___________________________________________________________________________________

Integument system

___________________________________________________________________________________

GU/GI system

____________________________________________________________________________________

Endocrine system

____________________________________________________________________________________

Musculoskeletal system

____________________________________________________________________________________

Mental Health

___________________________________________________________________________________

This student is medically capable of performing his/her duties as a student? Yes_____ No______

If no, please explain:

____________________________________________________________________________________

____________________________________________________________________________________

Signature ___________________________________ Date __________________

Printed Name________________________________________________________________________

/Credentials:________________________________________________________________________