SOUTHERN UNIVERSITY SHREVEPORT LOUISIANA

EXCELLENCE • INTEGRITY • ACCOUNTABILITY • SERVICE • DIVERSITY

Please Print Form

Dialysis Technician Department

A Certificate of Technical Studies Program - Division of Allied Health
610 Texas Street Suite 328, **Shreveport, LA 71101**

STUDENT HEALTH INFORMATION

Requirements regarding information of students admitted into the Dialysis Program are established in the interest of public safety.

Completion Guidelines:

STUDENT Health History: Completed by the student and reviewed by Physician.

IMMUNIZATION RECORD: Submit documentation**.**

HEALTH and PHYSICAL EXAM: Completed by the physician.

INFECTION CONTROL INFORMATION: Completed by the student.

DIALYSIS TECHNOLOGY DEPARTMENT

ADMISSION HEALTH INFORMATION FORM

STUDENT INFORMATION

U Number:	Last Four Digits of SS Number:	
Last Name	First Name	Middle Initial
Date of Birth	Sex	Marital Status
Street Address	APT# City State ZIP Code	
Telephone: Cell	Email:	

IN CASE OF EMERGENCY NOTIFY

Name	Telephone	Relationship
ADDRESS:		
Street Address	APT#	City/State/ZIP Code

ALLERGIES	YES	NO
LATEX*		
MEDICATION		
FOOD		
OTHER		

Health History (To be completed by the student and reviewed by physician)

HEALTH HISTORY	YES	NO	DATE
Hepatitis			
Tuberculosis			
Infectious Mononucleosis			
Heart Disease			
Diabetes			
Kidney Disease			
Seizure Disorders			
Injuries (last 6 months)			
Surgeries (Last 6 months)			
Illness (Last 6 months)			
Orthopedic Problems			
Respiratory Problems			
Mental Illness			
Hearing Problems			
Vision Problem			
Substance Abuse			
HIV			
Other Health Problems			
Allergies			

If you have answered **"YES"** to any of the above, list and describe here: _____

_____

_____

The above health information is true to the best of my knowledge. I understand that providing false information may result in my dismissal from the division.

I also understand that any change in my health necessitates informing the Respiratory Therapy Program and providing a physician statement of status

_____ _____

Student Signature **Date**

Reviewed by:

_____ _____

Physician's Signature **Date**

IMMUNIZATION RECORD

(Bring Copies of documentation)

IMMUNIZATION POLICY:
Louisiana State Law ***(ACT 1017)*** requires that all persons who are entering Louisiana colleges and universities for the first time and whose date of birth is after 1956, **must** submit proof of immunization against preventable and/or communicable diseases, including measles, mumps, rubella and tetanus-diphtheria (MMR, Td).
Other Immunizations and Titers are required by the clinical sites.

Copies from Health Unit are accepted. Others are the responsibility of the students and may be obtained from Health Unit, Pharmacies, Medical and Laboratory Clinics, Hospitals, or from your Personal Physician.

	DATE	RESULTS
Yearly TB Skin Test or blood test check for TB or		
Health Screen Form (within 12 months)		
MMR Vaccine (2) or Titer		
Varicella Vaccine (2) or Varicella Titer		
Tetanus (TD) every 10 years		
Hep B vaccine series or Titer if series completed.		
Urine drug screen		
Flu Vaccine season (9/23-4/24 or as indicated by CDC)		
Covid 19 Full vaccination before clinical		
Completed Health Form signed by Physician		

Physical Exam

Student Name: First _____ Middle Initial ____ Last: _____

Date of Birth: ___/ ____/ _____ Height: _____ Weight: _____

B/P: _____ Pulse: _____ Respiration _____

Check each item on the appropriate column:

	NORMAL	ABNORMAL	COMMENTS
Head, Face, Scalp, Skin			
Neck, Nodes, Thyroid			
Eyes, Nodes, Sinuses			
Mouth & Teeth			
Larynx & Tonsils			
Lungs & Chest			
Breasts			
Heart			
Abdomen, Hernia, Scars			
Extremities			
Spine & Musculoskeletal			
Neurological Reflexes			

Any Chronic Illnesses? _____ If YES, Explain _____

_____

_____

_____

Vision: _____ Hearing: _____

Physician's Signature: _____

Printed Name: _____

Printed Address: _____

_____

_____

Evaluation by a Physician

Students may be required to carry out a variety of physical activities, including the following. Please explain whether your patient can/cannot perform these activities.
(A ***"CANNOT"*** to any of these activities will indicate that you think your patient's health and/or safety will be jeopardized and therefore should not be in a clinical setting which would expose them to these activities.)

	CAN	CANNOT
Coordination and fine motor activities		
Lifting, moving, transferring activities		
Bending and twisting activities		
Reaching, pushing/pulling activities		
Strenuous and endurance activities		
Caring for patient with infectious disease		

***Indicate where not applicable**

Are there any other activities in which your patient cannot engage? Yes [ ] No[ ]

If YES, please specify _____
_____
_____
_____

If there are activities in which your patient cannot engage, when do you anticipate that he/she will be able to return to these activities?

Date: _____

If your patient is able to engage in all activities shown, do you release him/her to proceed in the program of Allied Health, Southern University at Shreveport? Yes [ ] No[ ]

COMMENTS: _____
_____
_____
_____

Physician's Signature: _____

Printed Name: _____

Printed Address: _____
_____
_____