Student Health Record

DATE_____

Check class level in nursing program:
Masters Student
DNP Student

Student's Statement **Win Number#**

Student's Name: (Last) (First) (MI)		**Date of Birth:**	**Gender:**
Address: (Street)			
(City) (State) (Zip Code)	**Home Phone: ( )** **Cell Phone: ( )**	**Email Address:**	
Name and Relationship of Emergency Contact: (Name)		**(Relationship)**	
Address and Phone Number of Emergency Contact: (Address)		**(Phone Number)**	

Personal Health History

	Yes	No			Yes	No			Yes	No	
1.			AIDS or HIV Infection	23.			Frequent indigestion	45.			Mononucleosis
2.			Anemia	24.			Gallbladder Disease	46.			Mumps
3.			Anorexia/Bulimia	25.			German Measles	47.			Palpitations
4.			Anxiety/Panic Disorder	26.			Glaucoma	48.			Peptic Ulcer Disease
5.			Arthritis	27.			Gum or Tooth Trouble	49.			Physical Disability
6.			Asthma	28.			Head Injury with LOC	50.			Pneumonia
7.			Autoimmune Disease	29.			Heart Disease	51.			Polio
8.			Back trouble	30.			Heart murmur	52.			Recent weight change
9.			Bladder Infections	31.			Hemorrhoids	53.			Recurrent Diarrhea
10.			Bleeding Disorder	32.			Hepatitis	54.			Rheumatic Fever
11.			Bronchitis	33.			Hernia	55.			Rupture (hernia)
12.			Cancer/Tumor/Cyst	34.			Hives	56.			Scarlet Fever
13.			Chest discomfort	35.			Hypertension	57.			Sinusitis
14.			Chicken pox/Shingles	36.			Insomnia	58.			Skin problems
15.			Chronic Cough	37.			Intestinal Disease	59.			STD/VD
16.			Diabetes	38.			Kidney Disease/Stones	60.			Smallpox
17.			Depression	39.			Learning Disability	61.			Stroke
18.			Diphtheria	40.			Liver Disease/Jaundice	62.			Thyroid Disease
19.			Dizziness/Fainting	41.			Loss of limb	63.			Tuberculosis/ +PPD
20.			Drug/Alcohol Problem	42.			Measles	64.			Urinary Tract Infection
21.			Epilepsy/Seizures	43.			Migraine Headaches	65.			Weakness/Paralysis
22.			Fractures	44.			Mitral Valve Prolapse	66.			Other:

COMMENT ON ALL "YES" ANSWERS:

A. **Has your physical activity been restricted during the past five years? YES NO**
If YES, Explain (providing reasons and durations):

B. **Do you have allergies? YES NO**

If YES, specify (food, medication, latex, other):

C. Do you take medications (prescribed, OTC, herbals, vitamins) regularly? YES NO
If YES, specify medication and reason taken:

I certify that the information contained on this form is true and correct. I understand that misrepresentation or omission of information will be sufficient grounds for dismissal from the nursing program

_____ _____
Student Signature **Date**

Physical Examination Form

TO THE HEALTHCARE PROVIDER: Please review the student's health history and complete the physical exam form. Please comment on all negative findings.

Height: _____ Weight _____

Temperature: _____Pulse: _____ Respirations: _____ Blood Pressure: _____/_____

A. Is the student free from communicable disease? YES NO

B. Is the student free from signs and symptoms of TB? YES NO
Comment on any NO answers_____

REVIEW OF SYSTEMS

Normal Abnormal	Notes: Describe abnormality
1. Skin 2. EENT 3. Cardiovascular 4. Respiratory 5. Musculo-Skeletal 6. Metabolic/Endocrine 7. Neuropsychiatric 8. Gastrointestinal 9. Genitourinary 10. Spine/Gait	
Visual Acuity: (SNELLEN) ___NORMAL___ABNORMAL DESCRIBE:	Gross Hearing: ___NORMAL___ABNORMAL DESCRIBE:

C. Is this student now under treatment for any medical or emotional condition? YES NO

D. Are there any limitations for physical activity (e.g. Patient Care)? YES NO

E. Are there any physical/psychiatric reasons why this student should not participate in clinical nursing courses?
YES NO

Comment on any YES answers:
_____

_____
_____

Printed Name of Healthcare Provider: _____Date of Exam: _____

Healthcare Provider Signature:
_____

Healthcare Provider Address:
_____

Healthcare Provider Phone Number:
_____