VERITAS NURSING ACADEMY

Student Health Assessment

Name ____ Date________/______/__________

Address ____

Date of Birth ____/______/______ Male _________ Female ________ Phone ____________________________

Please note: This health assessment must be completed by an MD, DO, PA or ARNP. Assessment by other health care providers will NOT be accepted.

PHYSICAL ASSESSMENT

Height _________ Weight ________Vital Signs: BP __________P _________R _________Temperature___________

Visual Acuity (R)_________(L)____________Uses Eyeglasses YES NO Uses contact lens YES NO

Hearing Acuity (R)_______________(L) ___________ Uses hearing aid YES NO

Immunization Record (must include dates)

MMR Date____/_______/_______ **Hepatitis Series** 1. Date________/_______/_______

Varicella **Date** __ /_/_______ 2. Date________/_______/_______

Seasonal flu Date ______/___/____ 3. Date________/_______/_______

Tetanus Diphtheria Acellular Pertussis (Tdap) Date__/_______/_______

MEDICAL HISTORY:

ALLERGIES	YES	NO	IF YES EXPLAIN_______________________________________
MAJOR ILLNESSES	YES	NO	IF YES EXPLAIN_______________________________________
HOSPITALIZATIONS	YES	NO	IF YES EXPLAIN_______________________________________
ORTHOPEDIC PROBLEMS	YES	NO	IF YES EXPLAIN_______________________________________
MAJOR SURGERIES	YES	NO	IF YES EXPLAIN_______________________________________
HEART PROBLEMS	YES	NO	IF YES EXPLAIN_______________________________________
LUNG PROBLEMS	YES	NO	IF YES EXPLAIN_______________________________________
ABDOMINAL PROBLEMS	YES	NO	IF YES EXPLAIN_______________________________________
MENTAL HEALTH PROBLEMS	YES	NO	IF YES EXPLAIN_______________________________________
CURRRENT MEDICATIONS	YES	NO	IF YES EXPLAIN_______________________________________

PHYSICAL ASSESSMENT (CONTINUED)

	Normal	Abnormal	Comments if Abnormal
Skin			
HEENT			
Heart			
Lungs			
Abdomen			
Musculoskeletal			
Neurological			

THE FOLLOWING DIAGNOSTIC TESTS ARE REQUIRED:

Please attach a copy of all lab results including titer levels

For the PPD, please attach additional documentation indicating the date received, read, and final result.

TITERS:	DATE	IMMUNE	NON-IMMUNE
Rubeola			
Rubella			
Mumps			
Varicella			
Hepatitis B (if immunized)			
Urinalysis	**DATE**	**NORMAL FINDINGS**	**ABNORMAL FINDINGS**
Hemoglobin/Hematocrit	**DATE**	**NORMAL FINDINGS**	**ABNORMAL FINDINGS**
***PPD** **1 Step** **2 Step**	**DATE**	**POSITIVE**	**NEGATIVE**

If PPD is positive the student must provide documentation of a negative chest x-ray and written medical clearance from any active chest disease. If any of these titers do not show immunity, the appropriate vaccine(s) or boosters are to be administered unless medically contraindicated as listed by the CDC.

Does this individual have any physical or mental conditions, disabilities or medical limitations that would prohibit the individual from functioning in the capacity of a Registered Nurse?

YES NO (if yes, state reason)____

____
Healthcare Provider Name and Title (PRINT)

____
Healthcare Provider Signature Date

____
Healthcare Provider Address City State Zip

(   )______________________________________
Healthcare Provider Telephone Number