Initial Health Appraisal Form

Health History Report

Information may not be released to a third party unless a proper acceptable authorization is furnished. This release must comply with State and Federal Regulations. Incomplete or inaccurate information may delay your clearance, cancel your registration or cause improper decision of your future medical care.

General Information

Name:_____ Social Security # _____/___/_____
Last First Middle

Date of Birth:_____/_____/_____ Age:_____ Sex (circle) M F

International Student: Yes No If Yes, what country?: _____

Entering Semester: Spring Summer Fall Year _____

Permanent Address: _____
Street or P.O. Box City State zip

Local Address : _____
Street or P.O. Box City State zip

Telephone Number: (____) _____ Cell: (____) _____ Work (____)_____

Emergency Contact-Name_____ Relationship_____ Phone#_____

Health and Accident Insurance

Medical Insurance Company_____ Policy Number_____

Address _____Name of Policy Holder_____

Students in the College of Nursing are required to show proof of health insurance. If you have no health insurance, you will be required to subscribe to the group policy through the University.

Authorization:
All statements in this form are true to my knowledge. I understand that this form is a part of my official application to the University. I agree to notify the Student Health Center of any change that occurs either prior to my registration or while I am a student at JSU.

_____
Date *Signature of Applicant*

_____
Date *Signature of Parent or Guardian if student is under 19 years of age*

Medical History

1. Do you smoke? Yes No If so, how much and for how many years? _____
2. Do you drink alcoholic beverages? Yes No If so, type and number of drinks per week: _____
3. Are you concerned about your utilization of alcohol or drugs? Yes No
4. Are you allergic to any medications, foods, environmental agents? Yes No
5. List any medications you currently take. Include over-the-counter and prescription medications.
   _____
   _____
   _____

Have you ever had or have you now

(Please check to the right of each item that applies, indicate year of first occurrence)

	Yes	No	Year		Yes	No	Year
Hypertension				Back, Bone or Joint Problems			
Heart Problems				Depression			
Asthma/Wheezing				Bipolar Disorder			
Tuberculosis				Anxiety/Panic Attacks			
Chronic Cough				LD/AD/ADHD			
Cancer				Hepatitis			
Alcohol/Drug Problem				Eating Disorder			
Seizures				Sickle Cell Anemia			
Frequent Headaches				Blood Disorders			
Diabetes				Thyroid problems			
Chickenpox				Eye or Hearing Problems			
Mononucleosis				Other			

Family History

Has any person related by blood had any of the following?

	Yes	No	Relationship		Yes	No	Relationship
High Blood Pressure				Glaucoma			
Stroke				Blood or Clotting Disorder			
Cancer				Alcohol Problems			
Heart Attack				Psychiatric			
Cholesterol				Suicide			
Diabetes				Drug Problems			

Physical Examination

Height:_____ Weight _____lbs. Temp_____ Pulse _____ RR _____ B/P_____

Vision: Corrected Right 20/____ Left 20/____
Uncorrected Right 20/____ Left 20/____

Contact Lenses: Yes No Glasses: Yes No
Ears: Is hearing normal Yes No

PLEASE EXAMINE AND COMMENT ON THE FOLLOWING SYSTEMS:

	Normal	Abnormal	Remarks or additional information
Head, Nose & Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Hernia			
Musculoskeletal			
Neuropsychiatric			
Skin			
Metabolic/Endocrine			
Organ loss or impairment			

Do you have any restrictions on your physical activities? Yes No if yes, explain _____

Are you taking any medication regularly at the present time, or have you taken any in the past? Yes No if yes, please verify medication: and dosage_____

Is student under treatment for any medical or emotional condition? Yes No If yes, explain _____
_____

Would you like a referral to the Counseling Center regarding the mental health resources on campus? Yes No

Jacksonville State University Immunization Requirements for Students

Disease	Primary Vaccine (MM/DD/YY)	Booster Vaccine (MM/DD/YY)	Serology Date/Results in lieu of vaccination proof
Measles (Rubeola) 2 Doses required			Rubeola lgG
Rubella (German Measles) 1 dose required			Rubella lgG
Mumps 2 doses Required			Mumps lgG
OR Combines as MMR 2 doses required			

If you were born after 1956 you should have two doses of the live measles vaccine or should show some evidence of measles immunity

Disease	Vaccine (MM/DD/YY)	Vaccine MM/DD/YY)
Tdap (give if Td booster has not been received in the last two years.) If Td booster has been given in the last two years, specify date. Tdap is not required		

Disease	Vaccine (MM/DD/YY)	Vaccine (MM/DD/YY)	Vaccine (MM/DD/YY)	Titer Test Date	Result
Hepatitis B				HBsAb	
Hepatitis B booster series					
Hepatitis A/B combo				HAsAb	

Disease	Vaccine (MM/DD/YY)	Vaccine (MM/DD/YY)	Vaccine (MM/DD/YY)	Serology Date/Results in lieu of disease documentation
Varicella 2 doses or VZV lgG				VZV lgG
Recommended (Optional)				
Meningococcal				
Influenza **Highly recommended				

	Placement Date (MM/DD/YY)	Date Read (48-72 hours) (MM/DD/YY)	Result in mm	CXR date needed for positive test	CXR result
TB Test **(must be given in the United States**) ***Must be given within 6 weeks prior to arrival to GSCC. Test must be read within 48-72 hours					
CXR Report					
Referral to County Health Department	Yes No	PPD> 5mm Yes No	TB high risk protocol recommended Yes No	Treatment Initiated Refused	Treatment Completed Yes No

Are there any existing or past abnormalities or conditions that might affect the student's health adversely during the nursing affiliation?

No _____ Yes_____ If yes, please explain _____

_____

Are there any existing or past abnormalities or conditions that might affect the student's ability to function in a health care agency?

No _____ Yes_____ If yes, please explain _____

_____

The student was examined on _____ and **was found** to be physically, mentally and emotionally healthy and **is released** to participate in all student activities, including activities requiring patient interaction in the medical setting. Additional comments/concerns:

The student was examined on _____ and **was not found** to be physically, mentally and emotionally healthy and/or **is not released** to participate in all student activities, including activities requiring patient interaction in the medical setting. Additional comments/concerns:

_____
Print name of Physician/Physician Assistant/Nurse Practitioner

_____ _____
Signature of Physician/Physician Assistant/Nurse Practitioner Date Office address/phone number

_____
Signature of student Date