Gadsden State Community College
Initial Health Appraisal Form

RMC Regional Medical Center Anniston

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:_____ Gender (circle) M F

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

Entering Semester: Spring Summer Fall Year _____

Student Number (G#)_____

e-mail Address:_____

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#_____

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 Health Science Program. I agree to notify the Dean of Health Science of any change that occurs either prior to my registration or while I am a student at GSCC.

_____
Date *Signature of Applicant*

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

TO BE COMPLETED BY STUDENT

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.
   _____
   _____
   _____

6. List any surgeries or procedures you have had and give the date for each.
   _____
   _____
   _____
   _____

7. Do you have any restrictions on your physical activities? Yes No
   If Yes, explain:_____

8. Are you under treatment for any medical or emotional condition? Yes No
   If Yes, explain:_____

Have you ever had or do you currently have:

(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			

TO BE COMPLETED BY EXAMINER

Physical Examination

Height:_____ Weight _____lbs. Date LMP:_____

Temp_____ Pulse _____ RR _____ B/P_____ Re-Check B/P (Manual)_____

Visual Acuity Testing

Distance Corrected Right 20/_____Left 20/_____ OU_____ Contact Lenses: Yes No Glasses: Yes No
Uncorrected Right 20/_____Left 20/_____ OU_____

Near Corrected Right 20/_____Left 20/_____ OU_____ Color Vision _____
Uncorrected Right 20/_____Left 20/_____ OU_____

Peripheral Vision: Right Temporal 85˚ 70˚ 55˚ Right Nasal: 45˚
Left Temporal 85˚ 70˚ 55˚ Left Nasal: 45˚

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			

Review of past Medical History, Surgical History and Medications
Additional Comments:

_____

_____

_____

_____

_____

_____

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 requires clearance** related to _____ from treating physician.

Clearance Received Date: _____

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

INDIVIDUAL IMMUNIZATION REPORT

Student Name _____

Program of Study_____

2 Step TB skin Test Must be given within 6 weeks prior to arrival to GSCC	**Placement Date (MM/DD/YY)**	**Date Read (48-72 hours) (MM/DD/YY)**	Result in mm	CXR needed for positive test or allergy	CXR result
PPD #1					
PPD #2					
Annual PPD					
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

Disease	**Vaccine (MM/DD/YY)**	**Vaccine (MM/DD/YY)**	**Vaccine (MM/DD/YY)**	**Titer Test Date HBsAb**	**Result**	**Immune**	**Not Immune**	**Non Converter**
Hepatitis B								
Hep B booster series								
Hepatitis A/B combo								

Disease	**Primary Vaccine (MM/DD/YY)**	**Booster Vaccine (MM/DD/YY)**	**Results Date**	**Immune**	**Not Immune**	**Post Series Titer Date**	**Post Vaccination Titer Results/Date Immunity Status**
Measles (Rubeola) 2 Doses required			Rubeola IgG				
Rubella (German Measles) 1 dose required			Rubella IgG				
Mumps 2 doses Required			Mumps IgG				
OR Combines as MMR 2 doses required							

Disease	**Td Vaccine (MM/DD/YY)**	**Tdap Vaccine (MM/DD/YY)**	**Exemption and Explanation**
Tdap: If Td booster has not been received in the last two years.			

Disease	**Vaccine (MM/DD/YY)**	**Vaccine (MM/DD/YY)**	**Titer Date**	**Result VZV IgG**	**Immune**	**Not Immune**	**Post Vaccination Titer Results/Date Immunity Status**
Varicella 2 doses							

Disease	**Vaccine (MM/DD/YY)**	**Vaccine (MM/DD/YY)**	**Exemption and Explanation**
Influenza			