Wright State University-School of Nursing
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https://health-education-human-services.wright.edu/nursing-kinesiology-and-health-sciences

INITIAL HEALTH ASSESSMENT REPORT

The information in this report is confidential. It will be used in case of an emergency situation. *All pages must be completed.*

Directions: *The student must complete Page 1 , 2 (Section I); read and sign page 5.*
Health Care provider is to complete Pages 3 & 4 (Section II) and Sign Page 5

Student Emergency information:

Last name _____

First name _____ Middle name _____

Birthdate _____

Local Address _____

City/State/Zip _____

Home phone _____ Work phone _____

Cell phone _____ WSU email _____

Emergency Contact Person:

Name _____

Relationship _____

Address _____

City/State/Zip _____

Home phone _____ Work phone _____

Cell phone _____

It is the student's responsibility to update the School of Nursing of any contact changes.

Name: _____ Birthdate: _____

SECTION I. HEALTH HISTORY (Student is to complete this section)

1. Your general health level is considered to be: (circle one)

Excellent Good Fair Poor

2. Have you had or do you now have any of the following:

	Yes	No	If yes, give details:
Allergies			
Asthma			
Seizures			
Diabetes			
Heart Disease			
Hepatitis			
High Blood Pressure			
Received treatment for Mental Health problems			
Received treatment for Substance abuse problems			

3. Corrective appliances. Please fill in the appropriate spaces

Appliances	Yes	No	If yes, specify
Glasses/Contacts			
Hearing Aid			
Braces on Extremities			
Prosthesis			

I verify the above information is accurate and complete regarding my health history.

Student Signature_____ Date _____

Name: _____ **Birthdate:** _____

NOTE: this page is only for the initial Physical Exam submission. For annual immunization renewals, please submit completed documentation indicating the immunization administered, date, name and credentials of person administering/reading and place where immunization was received.

SECTION II. HEALTH EXAMINATION

A report, signed by the physician, physician's assistant or nurse practitioner, shall be provided to the nursing program. This report shall indicate whether the student does or does not have any health condition(s) which would create a hazard to themselves, employees, or patients.

1. Date of Examination_____ Height _____ Weight_____
   Blood pressure_____ Pulse_____ Respirations_____

2. Clinical evaluation: (may attach copy of agency health form)

Clinical Evaluation	Normal	Abnormal	Comments
Skin			
Head, ears, eyes, nose, throat, including hearing and visual acuity			
Mouth, teeth and gums			
Neck and thyroid			
Lungs, chest			
Heart (supine and upright)			
Abdomen			
Back/spine			
Extremities/musculoskeletal			
Neurologic			
Emotional/psychological			
Cognitive function			
Motor function			
Sensory function			
Other findings			

SECTION III. Immunization/Health Screening. Please complete or include immunization history with this form.

Immunity to communicable diseases is crucial for your safety and the safety of those for whom you care. An initial immunization status determination is essential for all students entering the School of Nursing.
Pregnant students should consult with their healthcare provider prior to receiving immunizations.

TDaP Tetanus/Diphtheria/Pertussis (must be within last 10 years; Td not accepted).
Date of last immunization _____

Measles, Mumps and Rubella (MMR). One of the following is required:
(1) Two vaccinations dates #1_____ dates #2 _____
If the series is in process, submit what has been received; the series should be completed as due.
OR
(2) Positive antibody titer for all three components (lab report required)
If any titer is negative or equivocal, the student must to receive one booster and provide a second titer.

If born before January 1, 1957, you are considered to have presumptive immunity. However, you should consider immunization in the event of a disease outbreak.

Name: _____ **Birthdate:** _____

Varicella (chicken pox) One of the following is required:

(1) Two vaccinations dates #1_____ dates #2 _____

If the series is in process, submit what has been received; the series should be completed as due.

OR

(2) Positive antibody titer (VZV IgG ANTIBODY)

If any titer is negative or equivocal, the student must to receive one booster and provide a second titer.

Hepatitis B vaccine series

2 doses given 4 weeks apart; 3rd dose 5 months after second – *AND* - Hepatitis B surface antibody qualitative titer required.

Dates of Immunizations #1 _____ #2_____ #3_____

Date of titer: _____ Result: ❑ pos ❑ neg

If titer is negative, a booster or repeat of the series should be given, per the decision of the health care provider.

Date of booster: _____

Dates of second series of immunizations #1 _____ #2_____ #3 _____

Tuberculosis Skin Screening: Documentation of one of the following must be provided **upon admission** to the nursing program:

(1) Initial Two-Step Mantoux (2 skin tests, one and two should be between 1 and 3 weeks apart)

Step one date: _____ Result: __pos __ neg

Step two date: _____ Result: __ pos __ neg

OR

(2) Medical documentation of at least two consecutive negative annual Mantoux screenings; one must be during the current year

Annual screen one date: _____ Result: __pos __ neg

Annual screen two date: _____ Result: __ pos __ neg

OR

(3) Chest x-ray indicating no evidence of tuberculosis

Date _____ results _____

OR

(4) Negative T-Spot or QuantiFERON Gold TB test date: _____ Result: __ pos __ neg

If any of the above are positive, documentation by the healthcare provider must be submitted regarding appropriate follow-up testing and treatment.

In subsequent academic years, one of the following must be completed before the anniversary date of the initial testing:

(1) For negative Mantoux reactors, annual Mantoux screen
(2) For all others, an annual symptom review must be completed

NOTE: If you travel out of the country, a TB test (Mantoux, chest-ray or blood test) will be required to meet the annual TB requirement.

Influenza (flu) vaccine

Documentation of annual vaccination must be submitted prior to October 1st for the current flu season. Spring admits must submit documentation by December 15th.

Date of last immunization: _____

Name: _____ **Birthdate:** _____

HEALTH CARE PROVIDER VERIFICATION

I have verified that this individual I have examined is the named individual on this form and find the following (please check all that apply):

_____ The student is free of any medical condition and/or contagious disease and does not pose a health risk to others.

_____ The student is free of any mental or physical impairment that would prevent the student from meeting his/her clinical practicum training obligation.

_____ The student has the following condition which could interfere with the performance of his/her essential nursing duties and needs to follow-up with the University Disability Services to determine what accommodations would be reasonable in the clinical setting. _____

_____

Signature of healthcare provider

_____

Printed name of healthcare provider

_____

Address/Street/City/State/Zip Telephone

_____

Date form completed

_____

Student is to read and sign:

The School of Nursing must meet all health requirements by contracted clinical agencies/partners, in order for students to have the opportunity to obtain clinical experiences. Should additional requirements occur by clinical partners while the student is enrolled in the nursing program, the student will be required to complete these, at their expense. This would include, but is not limited to, vaccines, lab testing or background checks.

I understand, and will meet, all health requirements as outlined by the School of Nursing and clinical partners.

_____ _____

Student Signature **Date**