



**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**  
**Student Physical Form**

The information in this report is confidential. It will be used in case of an emergency situation. *All pages must be completed with the student's name and DOB on each page.*

**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.

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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.

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**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; 3<sup>rd</sup> 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.

**BCG Vaccination**

If you have received a BCG vaccination, please obtain a chest x-ray or TB Blood test (QuantiFERON Gold or T-spot) to meet the initial TB requirement.

In subsequent academic years for the annual TB renewal, the ***Tuberculosis Self Report*** Form can be completed if the initial screening was negative.

**Influenza (flu) vaccine**

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

Date of last immunization: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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**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 and is recommended to follow-up with the University Disability Services to determine what accommodations would be reasonable in the clinical setting. \_\_\_\_\_

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\_\_\_\_\_  
Signature of healthcare provider

\_\_\_\_\_  
Printed name of healthcare provider

\_\_\_\_\_  
Address/Street/City/State/Zip

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Date form completed

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**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**