HEALTH INFORMATION FORM
Fairmont State University School of Nursing & AHA

TO BE COMPLETED BY THE STUDENT:

Must be completed and returned to the School of Nursing by August 1, 2010

NAME____
(Last) **(First)** **(MI)**

Gender: Male/Female **Date of Birth:** ____________________________

Current Medications: ____

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Allergies/Reactions: ____

____

Do you consider yourself in good health? Yes/No

If not, explain:

List any serious illness/es:

List any operations and/or broken bones

Fairmont Address _____________________________ **Phone**_________________

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Home Address ____

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Emergency contact person ______________________**Phone**_________________

Primary Care Provider __________________________**Phone**_________________

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Height ___________ **Weight** ___________ **BP** _________ **Pulse**______

	Normal	Describe if abnormal
Speech		
Eyes/Visual Acuity		
Ears/Hearing		
Nose		
Mouth		
Throat		
Thyroid		
Neck		
Nodes		
Heart		
Lungs		
Breasts		
Abdomen		
Musculoskeletal		
Skin		
Neurological		

At this time, is there any known health problem/condition which would prevent this student from completing the FSU Associate Degree Nursing Program?

____
Signature/Health Care Provider **Title** **Date**

FAIRMONT STATE UNIVERSITY

SCHOOL OF NURSING AND ALLIED HEALTH ADMINISTRATION

REQUIRED PRIOR TO ADMISSION	DATE	RESULTS
2-Step PPD-2 separate skin tests, 2 weeks apart-if a PPD is obtained annually for work, the dates of the last 2 PPD's may be used. If there is a history of prior PPD's, 2 skin tests **no longer than 12 months apart** can be used.		
Chest X-Ray report (Required only if the PPD is **positive**)		
Measles, Mumps and Rubella immunity-must have copy of **lab report** listing **positive** titer results for all 3 components. If **negative or equivocal,** proof of a **booster** immunization will be required.		
Varicella immunity-must have copy of **lab report** listing **positive** titer result. If **negative or equivocal** a **booster immunization** is required. **History of chicken pox is not adequate proof of immunity.*		
Hepatitis B Immunity –series must be started prior to **August 1, 2010**. Must have lab proof of series of 3 immunizations. ***Sequence of immunizations follows:*** 1st immunization 2nd immunization-1 month after the first 3rd immunization-5 months after the 2nd		
Hepatitis B titer Copy of lab report listing **positive** titer results, this should be drawn **2 months** after the 3rd immunization. If titer is **negative**, another 3-dose vaccine series is required with another titer to determine results.		
Tdap immunization-combined Adult Tetanus, Diptheria, Pertussis Vaccine. Adacel Vaccine (required within 10 years of admission). If you only received the tetanus immunization the Tdap is required 2 years after the tetanus immunization.		
Drug Screening-5-panel urine drug screen given after **June 1, 2010** and **prior to July 31, 2010**. Must be current annually.		

- **PROOF MEANS A COPY OF IMMUNIZATION RECORD FROM THE INDIVIDUAL WHO GAVE THE IMMUNIZATION OR A COPY OF THE LAB REPORT FROM THE TITER, NOT THE PHYSICIAN'S INITIALS.**

At this time, is there any known health problem/condition which would prevent this student from completing the FSU Associate Degree Nursing Program?

OTHER COMMENTS

Signature/Health Care Provider **Title** **Date of Examination**