

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, 2009

NAME _____
 (Last) (First) (MI)

Gender: Male/Female Date of Birth: _____

Current Medications: _____

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 _____

Home Address _____

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
PPD (Within 1 year and annually)		
Chest X-Ray (Required only if positive PPD result)		
Rubella Immunity (must have proof of 2 MMR immunizations or copy of lab record listing positive titer results)		
Varicella Immunity (must have proof of Varicella immunizations or copy of lab report with positive titer results) <i>*History of chicken pox is not adequate proof of immunity</i>		
Hepatitis B Immunity Must have proof of lab report with positive titer results or proof of initial dose of series prior to August 1 st) *The series must be completed by 3rd semester of school and proof of positive titer results 6 months after 3rd immunization. A 4th immunization (booster) is required if titer results are not positive.		
Tetanus Toxoid (required within 10 years of admission)		

➔ **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

Mail to: Fairmont State University
 School of Nursing & AHA
 1201 Locust Avenue
 Fairmont, WV 26554

