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WRIGHT STATE UNIVERSITY-MIAMI VALLEY
COLLEGE OF NURSING & HEALTH
Undergraduate or Graduate

WSU Email:_____ UID # U_____

INITIAL HEALTH ASSESSMENT REPORT

The information in this report is confidential. It may be necessary to provide health care agencies with general information, when needed, to individualize your program.

Student information:

Last name _____

First name _____

Middle name _____

Maiden name _____

Birthdate _____

Local Address _____

City/State/Zip _____

Home phone _____

Work phone _____

Cell phone _____

Emergency Contact Person:

Name _____

Relationship _____

Address _____

City/State/Zip _____

Home phone _____

Work phone _____

Cell phone _____

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			
Convulsions			
Diabetes			
Heart Disease			
Hepatitis			
High Blood Pressure			
Kidney Disease			
Received treatment for Mental Health problems			
Received treatment for Substance abuse problems			
Rubella (German Measles)			

3. Corrective appliances. Please fill in the appropriate spaces

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

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

Date _____ Student Signature_____

SECTION II. HEALTH EXAMINATION (to be completed by Physician or Nurse Practitioner)

1. Date of Examination_____ Height _____ Weight_____

Blood pressure_____ Pulse_____ Respirations_____

2. Review of systems. (may attach copy of agency health form)

HEENT

Chest

Abdomen
Back and Spine

Extremities

Are there any health restrictions or health problems for this student which may need to be considered in planning his/her nursing program? If yes, please describe.

Summary of Health Status:

Name: birthdate:

SECTION III. IMMUNE STATUS (to be completed by Physician or Nurse Practitioner)

Immunization History

Immunity to common childhood 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 College of Nursing and Health. Pregnant students should NOT be immunized. If the immunization is given the student should not become pregnant for at least three months. A reproductive history and examination is essential prior to immunizing susceptible students.

1. TDaP Tetanus/Diptheria/Pertussis (must be within 10 years; TD not accepted) Date of Immunization _____

2. MMR - 2 MMR immunizations – *OR* - positive rubeola *and* rubella titers

Dates of MMR Immunizations #1 _____ #2_____

If no documentation of 2 MMRs, both rubeola and rubella titers should be drawn:

Rubeola (Measles) Titer (required only if no record of 2 MMRs) Titer date _____ Result: □ pos □ neg

If titer is negative, immunization dates: #1_____ #2_____

Or physician diagnosed rubeola date: _____

Rubella Titer (required only if no record of 2 MMRs) Titer date: _____ Result: □ pos □ neg

If titer is negative, immunization dates: #1_____ #2_____

3. Varicella (Chicken pox) - 2 doses of varicella vaccine – *OR* - Varicella Zoster Antibody – IgG titer
(history of disease is not accepted)

Dates of Varicella immunizations #1_____ #2_____
OR
Date of titer: _____ Result: □ pos □ neg

If titer is negative, immunization dates: #1_____ #2_____

4. Hepatitis B vaccine series – *AND* - Hepatitis B surface antibody qualitative titer required.
Dates of Immunizations #1 _____ #2_____ #3_____ Date of titer: _____ Result: □ pos □ neg

If titer is negative, immunizations AND titer should be repeated:
Dates of Immunizations #1 _____ #2_____ #3_____ Date of titer: _____ Result: □ pos □ neg

5. Tuberculosis Skin Screening: Documentation of one of the following must be provided:

- Initial Two-Step Mantoux (Steps one and two should be between 1 and 3 weeks apart)
  Step one date: _____ Result: □ pos □ neg Step two date: _____ Result: □ pos □ neg
- Initial Two Step Mantoux with subsequent negative annual mantoux screens, including a current screen
  Step #1 date: _____ Result: □ pos □ neg Step #2 date: _____ Result: □ pos □ neg
  Annual screen date: _____ Result: □ pos □ neg Annual screen date: _____ Result: □ pos □ neg
- Medical documentation of at least three consecutive negative annual mantoux screens, including a current screen
  Annual screen date: _____ Result: □ pos □ neg Annual screen date: _____ Result: □ pos □ neg
  Annual screen date: _____ Result: □ pos □ neg Annual screen date: _____ Result: □ pos □ neg

Positive TB Skin Reactors: Documentation of one of the following must be provided:

- Initial Chest xray date: _____ Result: _____
  Thereafter, Annual Symptom Review with Health Care Provider required: date: _____
  OR
- QuantiFERON Gold TB test date: _____ Result: □ pos □ neg
  Thereafter, Annual Symptom Review with Health Care Provider required: date: _____

Has this student received BCG vaccine? Yes ___ No ___ Has this student received INH therapy? Yes ___ No ___

6. Flu shot or mist annually prior to fall semester. (Spring admit students must have by Dec 15) Date: _____

_____
Physician or Nurse Practitioner (Please stamp or print legibly)

_____
Address/Street/City/State/Zip Telephone

Date_____ Signature _____