MSN Health Appraisal Form

The individual named below is a candidate for admission to the College of Nursing and Health Sciences. Your cooperation in performing the pre-entrance health examination and completing this form will assist both the applicant and the College.

Name: _____ _____ Date of birth:_____

Address: _____ Student ID: _____ Phone:_____

City: _____ State:_____ Zip: _____

In an emergency notify: _____ Phone:_____

Medical History of Family:

Please include heart or kidney disease, cancer, hypertension, diabetes, mental or nervous disorders, and other chronic illnesses. **If no significant family history, indicate "NONE".**

_____

_____

Medical History of Applicant:

Explain positive responses below.

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
Previous Hospitalizations	☐	☐	Injuries	☐	☐	Mental or Emotional Problems	☐	☐
Childhood Diseases	☐	☐	Operations	☐	☐	Shortness of Breath/Pneumonia	☐	☐
Congenital Disorders	☐	☐	Epilepsy	☐	☐	Current Medication/Therapy	☐	☐
Cardio Vascular	☐	☐	Allergies	☐	☐	Other Diseases	☐	☐
Genitourinary	☐	☐	Respiratory Illnesses	☐	☐	Other Significant Medical History	☐	☐

_____

Physical Examination:

Height	Weight	Blood Pressure	Pulse	Glasses Contacts

Check the appropriate box. **Explain abnormal findings below.**

	Normal	*Abnormal*		*Normal*	*Abnormal*		*Normal*	*Abnormal*
Head	☐	☐	Neuro	☐	☐	Abdomen	☐	☐
Eyes	☐	☐	Thyroid	☐	☐	Extremities	☐	☐
Ears	☐	☐	Chest	☐	☐	Skin	☐	☐
Nose	☐	☐	Lungs	☐	☐	Breasts	☐	☐
Throat	☐	☐	Heart	☐	☐	Genital (If clinical indicated)	☐	☐

_____

_____

Are there any existing or past abnormalities or conditions that might affect his/her health adversely during the nursing affiliation? No☐ Yes☐ please explain

_____

Are there any existing or past abnormalities or conditions that might affect his/her ability to function in a health care agency? No☐ Yes☐ please explain

_____

Please attach additional sheets of paper if needed to describe abnormal conditions.

_____ _____

MD, NP or PA Signature❋ **Date**

_____ _____

MD, NP or PA Signature Printed Name **Name of Provider's Practice/Agency/Organization**

_____

Address **City** **State** **Zip**

❋Cannot be signed by a RN or MD's office personnel.

Name: _____ Student ID: _____

Required Immunizations:

Proof of immunity must be validated through documentation of the dates that the vaccines were given, a copy of an immunization record (attach copy), or a copy of a laboratory antibody titer test indicating a positive immune status (attach copy of lab report). **Cannot be signed by a RN or MD's office personnel.**
Must be documented by health care provider, MD, NP or PA ONLY (not to be written by student).

#1. Hepatitis B (Required) _____ (Date given) _____ (MD, NP or PA Signature or Official Clinic Stamp Only✱) _____ (Date)

#2. Hepatitis B (Required) _____ (Date given) _____ (MD, NP or PA Signature or Official Clinic Stamp Only✱) _____ (Date)

#3. Hepatitis B (Required) _____ (Date given) _____ (MD, NP or PA Signature or Official Clinic Stamp Only✱) _____ (Date)

Titer (see note below) _____ (Test Date) _____ (Result) _____ (MD, NP or PA Signature or Official Clinic Stamp) _____ (Date)

Note: Anti-HBs testing is not recommended routinely for previously vaccinated health care providers (HCPs) who were not tested 1-2 months after their original vaccine series. These HCPs should be tested for anti-HBs when they have an exposure to blood or body fluids. If anti-HBs negative, the HCP should be treated as if susceptible.

Required: Two-step PPD Tuberculin Skin Test

Must be administered no earlier than 6 weeks prior to admission.
The test **must be read in 48-72 hours** after administration.

_____ (Date Given) _____ (Date Read) _____ (Result) _____ (MD, NP or PA Signature or Official Clinic Stamp Only✱) _____ (Date)

_____ (Date Given) _____ (Date Read) _____ (Result) _____ (MD, NP or PA Signature or Official Clinic Stamp Only✱) _____ (Date)

Note: If one verifies by supporting documentation a 2-step PPD in the past with yearly PPDs thereafter, a current PPD is the only requirement.

If the student had a positive PPD TB test in the past or if BCG vaccine was received, a negative chest x-ray report is required.

☐ Chest x-ray of _____ (Date) was within normal limits and showed no evidence of infection.

Physician's recommendation is required for follow-up evaluations after an initial negative chest x-ray:

☐ Needs no further chest x-ray, unless student becomes symptomatic with a respiratory disease.

☐ Needs yearly chest x-ray.

☐ Other, explain: _____

_____ (MD, NP or PA Signature or Official Clinic Stamp Only✱) _____ (Date)

✱Cannot be signed by a RN or MD's office personnel.

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Varicella (must state history of disease, titer, or dates of vaccine)

History of Disease *(check one)* *Yes*☐ *No*☐ _____ _____
MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

- - - - - - - - - - - - - - - - OR - - - - - - - - - - - - - - - - - -

Titer *(check one)* *Yes*☐ *No*☐ ***If yes, attach a copy of the lab report***

_____ _____
MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

- - - - - - - - - - - - - - - - OR - - - - - - - - - - - - - - - - - -

Shot # 1 _____ _____ _____
Date given MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

Shot # 2 _____ _____ _____
Date given MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

MMR

Shot # 1 _____ _____ _____
Date given MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

Shot # 2 _____ _____ _____
Date given MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

- - - - - - - - - - - - - - - - OR - - - - - - - - - - - - - - - - - -

Rubeola Titer *(check one)* *Yes*☐ *No*☐ ***If yes, attach a copy of the lab report***

_____ _____
MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

Rubella Titer *(check one)* *Yes*☐ *No*☐ ***If yes, attach a copy of the lab report***

_____ _____
MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

Mumps Titer *(check one)* *Yes*☐ *No*☐ ***If yes, attach a copy of the lab report***

_____ _____
MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

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Td booster _____ _____ _____
Date given | MD, NP or PA Signature or Official Clinic Stamp Only❋ | Date

(Td Booster required every 10 years. A one-time does of Tdap should be given if TD booster has not been received in the last two years.)

Tdap _____ _____ _____
Date given | MD, NP or PA Signature or Official Clinic Stamp Only❋ | Date

❋**Cannot be signed by a RN or MD's office personnel.**