

Auburn University College of Nursing Health Form

Banner ID _____
(NO social security numbers)

Name _____ Date of Birth ____/____/____
LAST FIRST Preferred Name M.I.

Name of Parent(s) or Guardian _____ Phone ____-____-____

Permanent Address

City _____ State _____

Zip _____

Cell Phone ____-____-____

Home Phone ____-____-____

Auburn Address

City _____ State _____

Zip _____

Cell Phone ____-____-____

Home Phone ____-____-____

STATEMENT AND CONSENT

ANY INCORRECT INFORMATION ON THIS FORM MAKES STUDENT SUBJECT TO DISMISSAL FROM THE NURSING PROGRAM.

I hereby give my permission to release to the Auburn University College of Nursing, this and any additional information regarding my health status. I understand this to be used for enrollment and teaching purposes only.

 Student Signature Date Printed Name

I certify that the information given on this form is true and correct, and I have no abnormality, limitation, or restriction not mentioned on this document. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any requested information will constitute sufficient grounds for dismissal from Auburn University College of Nursing. I agree to notify the College of Nursing of any change in my physical or mental health that might negatively impact my ability to perform my duties or might have a negative impact of my patient or coworker either prior to my registration or while I am a student. I acknowledge by my signature that I have read and understand these statements.

 Student Signature Date Signed

Do You Have Present or Past History Of (Y/N)

- | | | |
|-------------------------------------|---|---|
| 1. ___ Eye Problems | 13. ___ High Blood Pressure | 25. ___ Diabetes |
| 2. ___ Colorblind | 14. ___ Ulcer (Stomach/Duodenal) | 26. ___ Epilepsy or Seizures |
| 3. ___ Ear, Nose, or Sinus Problems | 15. ___ Allergies | 27. ___ Headaches |
| 4. ___ Throat/Tonsillar Infections | 16. ___ Colitis/Enteritis | 28. ___ Depression |
| 5. ___ Infectious Mononucleosis | 17. ___ Hepatitis; Type if known _____ | 29. ___ Anxiety or Tendency to Worry |
| 6. ___ Asthma | 18. ___ Bladder or Kidney Infection | 30. ___ Skin Problems |
| 7. ___ Tuberculosis | 19. ___ Kidney Stone | 31. ___ Measles; Type if known _____ |
| 8. ___ Other Lung Functions | 20. ___ Blood Clotting Problems | 32. ___ Mumps |
| 9. ___ Rheumatic Fever | 21. ___ Congenital or Birth Defects | 33. ___ Chicken Pox |
| 10. ___ Heart Murmur | 22. ___ Cancer or Malignancy | 34. ___ Gynecological Problems |
| 11. ___ Chest Pain | 23. ___ Anemia or Blood Disorder | 35. ___ Bone or Joint Problems |
| 12. ___ Rapid Heart Beat | 24. ___ Thyroid Disorder | 36. ___ Back Problems |

If any of the above questions are answered "yes" please explain _____

Student Name _____

PULSE _____ Blood Pressure _____ TEMP _____

EYES: Are glasses worn? No () Yes () Ears: Is hearing normal? No () Yes () Is colorblind? No () Yes ()

NOTE: Wearers of contact lenses should be advised to have a pair of regular glasses for alternate use.

Distant Vision:

Righth20/____ Corrected to 20/____ Left 20/ ____ Corrected to 20/ ____

Skin	Normal () Abnormal ()	Heart	Normal () Abnormal ()
Head, Face, Neck	Normal () Abnormal ()	Nose & Sinuses	Normal () Abnormal ()
Vascular System	Normal () Abnormal ()	Abdomen	Normal () Abnormal ()
Mouth & Throat	Normal () Abnormal ()	Teeth	Normal () Abnormal ()
Lungs & Chest	Normal () Abnormal ()	Endocrine System	Normal () Abnormal ()
Neurologic	Normal () Abnormal ()	Spine	Normal () Abnormal ()

Are Muscle Strength and Function of Extremities Normal and All Digits Present? NO () YES ()

NOTE: Students must possess the functional ability to perform the skills and demonstrate the behaviors required of a professional nurse. These abilities include but are not limited to (a) adequate vision, such as that required to observe changes in physical conditions, to read small print on labels and reports, and to discern subtle changes in color; (b) adequate hearing, such as that required to distinguish muted sounds through a stethoscope; (c) fine motor skills and manual dexterity, such as required to handle small, delicate equipment; (d) strength to turn and assist with lifting adults, and to lift and carry children; (e) the mobility to perform skills and respond quickly in emergency situations; (f) the ability to communicate and interact effectively with others, verbally and in writing; and (g) the ability to detect odors.

PHYSICIAN'S OPTION: Is There or Has There Been Any Physical or Emotional Problem That Is Likely to Interfere with the Student's Adjustment or Activities within THE AUBURN UNIVERSITY COLLEGE OF NURSING? No () Yes () If Yes please explain below:

Please list any regular prescription medication and reason for taking:

*College of Nursing requires Antibody Titer in Hepatitis B and vaccines in MMR, Varicella, Tdap, and Flu. If you have any ongoing medical conditions, please have your primary care provider send a written report stating you are capable of performing the duties of a nurse and that your condition poses no threat to patients or coworkers.

Signed: _____ Date: _____

(Must be signed by MD or NP)

Clinic Address: _____

City: _____ State: _____ Zip: _____