Auburn University School 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 School 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 School of Nursing. I agree to notify the School 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
2. ___Colorblind
3. ___ Ear, Nose, or Sinus Problems
4. ___ Throat/Tonsillar Infections
5. ___ Infectious Mononucleosis
6. ___ Asthma
7. ___Tuberculosis
8. ___Other Lung Functions
9. ___Rheumatic Fever
10. ___ Heart Murmur
11. ___Chest Pain
12. ___Rapid Heart Beat
13. ___ High Blood Pressure
14. ___ Ulcer (Stomach/Duodenal)
15. ___Allergies
16. ___ Colitis/Enteritis
17. ___ Hepatitis; **Type if known_____**
18. ___ Bladder or Kidney Infection
19. ___ Kidney Stone
20. ___ Blood Clotting Problems
21. ___Congenital or Birth Defects
22. ___ Cancer or Malignancy
23. ___ Anemia or Blood Disorder
24. ___ Thyroid Disorder
25. ___ Diabetes
26. ___ Epilepsy or Seizures
27. ___ Headaches
28. ___ Depression
29. ___ Anxiety or Tendency to Worry
30. ___ Skin Problems
31. ___ Measles; **Type if known_____**
32. ___ Mumps
33. ___ Chicken Pox
34. ___ Gynecological Problems
35. ___ Bone or Joint Problems
36. ___ Back Problems

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

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:

Rigth20/____ 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 SCHOOL OF NURSING? No ( ) Yes ( ) If Yes please explain below:

_____

Please list any regular prescription medication and reason for taking:

_____

***School of Nursing requires Antibody Titer for those students who have no history of chickenpox, mumps, or are uncertain of their immunity. 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: _____