

**Georgia Southwestern State University
School of Nursing
Student Statement of Health**

Program _____

Name _____ GSW ID or Social Security Number _____

Permanent Mailing Address:
 _____ City _____ State _____ Zip Code _____

Date of Birth _____ Phone: _____

Part I: Health History: (To be completed by the Student)

Past Health

General Health _____	Serious or Chronic Illnesses _____
Significant Childhood Illnesses _____	Hospitalizations _____
Operations _____	Accidents or Injuries _____
Allergies ___ (yes) ___ (no) If yes, please specify below	
Medication: _____	Food: _____ Insects: _____

Are you now taking any medications? ___ (no) ___ (yes)
 If yes, please list: _____

Please indicate whether you have had any of the following conditions or symptoms. Check in boxes provided and explain in details in the spaces provided at the bottom. Attach a separate sheet if necessary.

Condition	No	Yes	Condition	No	Yes	Condition	No	Yes
Anxiety			Eye Injury or Disease			Neurological disorder		
Arthritis			Frequent Headaches			Pneumonia		
Asthma			Heart Disease			Rheumatic fever		
Back Problems			Heart Murmur			Seizures		
Blood Disorder/Anemia			Hepatitis			Skin problems		
Bone, Joint, or muscle problems			Hernia			Sexually transmitted disease(s)		
Breast problems			High blood pressure			Thyroid problems		
Cancer			Inflammatory bowel disease			Tuberculosis		
Chicken Pox			Kidney problems			Ulcers (stomach)		
Depression			Malaria			Urinary infections/disease		
Diabetes			Migraine headaches			Other		
Drug or alcohol problems			Mononucleosis					
Eating Disorder								

Do you have any physical or mental challenges or conditions* that may impact your activity? ___ (no) ___ (yes)
 * See the *Essential Technical Standards* in the *Student Handbook*. All nursing students must demonstrate the ability to meet the *Essential Technical Standards* with or without reasonable accommodation upon admission and throughout the nursing program
 Details of any conditions noted above _____

To the best of my knowledge, all medical history statements are true with no abnormality, limitations, or restrictions not mentioned in this record. The School of Nursing will be notified of changes in physical or mental health prior to registration and throughout my enrollment in the nursing program.

Student Signature: _____ Date: _____

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School of Nursing
Student Statement of Health**

Part II. Immunizations: To be completed by physician or health care facility

Name _____ Date of Birth _____ GSW ID or SSN _____

VACCINE	REQUIREMENT	REQUIRED FOR:
MMR (Measles, Mumps, Rubella combined shot)	<ul style="list-style-type: none"> 2 doses #1 ___/___/___ #2 ___/___/___ 	<ul style="list-style-type: none"> Students born in 1957 or later
Measles (Rubeola)	<ul style="list-style-type: none"> 2 doses #1 ___/___/___ #2 ___/___/___ Or Titer _____ 	<ul style="list-style-type: none"> Students born in 1957 or later If titer done, attach results
Mumps	<ul style="list-style-type: none"> 2 doses #1 ___/___/___ #2 ___/___/___ Or Titer _____ 	<ul style="list-style-type: none"> Students born in 1957 or later If titer done, attach results
Rubella (German Measles)	<ul style="list-style-type: none"> 1 Dose #1 ___/___/___ Or Titer _____ 	<ul style="list-style-type: none"> All students If titer done, attach results
Varicella (Chicken Pox)	<ul style="list-style-type: none"> 2 doses #1 ___/___/___ #2 ___/___/___ Or Titer _____ Or History of chicken pox or shingles 	<ul style="list-style-type: none"> All U.S. born students born in 1980 or later All foreign born students regardless of year born If titer done, attach results
Tetanus and Diphtheria (Td or Tdap)	<ul style="list-style-type: none"> Td ___/___/___ Or Tdap ___/___/___ 	<ul style="list-style-type: none"> Alls students must have one dose within 10 years
Hepatitis B	<ul style="list-style-type: none"> 3 Dose series #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ Antibody/Antigen Results Test date: ___/___/___ Results _____ 	<ul style="list-style-type: none"> All nursing students
Hepatitis A (Recommended)	<ul style="list-style-type: none"> 2 doses #1 ___/___/___ #2 ___/___/___ 	
Meningococcal (Recommended)	<ul style="list-style-type: none"> ___/___/___ 	
Influenza (Recommended)	<ul style="list-style-type: none"> ___/___/___ 	<ul style="list-style-type: none"> Recommended annually

Tuberculosis Screening skin test (PPD) ___/___/___
 Results: ___ mm Pos _____ Neg _____ (If positive, a chest X-ray is required)
 If indicated, attach chest x-ray report from US healthcare facility
 X-ray result: Date ___/___/___

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name: _____ Signature _____
 Address: _____
 Date of Issue: _____ Telephone _____

Student to return form via student tracking system included in acceptance packet within two weeks of receipt.

Georgia Southwestern State University
School of Nursing
Physical Exam Form

NAME _____ STUDENT ID or Social Security Number _____

Part III. To be completed by physician or certified nurse practitioner and returned prior to beginning the nursing program. Back of form may be used for additional comments when necessary. Mail or deliver completed form to: **Student Services Coordinator, School of Nursing, Georgia Southwestern State University, 800 GSW State University Drive, Americus, GA 31709**

1. Vision normal with correction () without glasses () Color vision defective? No () Yes ()
2. Hearing normal? No () Yes ()
3. Blood Pressure _____ Within normal limits? No () Yes ()
4. Height _____ inches Weight _____ pounds BMI _____
5. Physical Examination Comment on abnormalities on back of form

System	Normal	Abnormal	System	Normal	Abnormal
Skin			Abdomen		
Head, Face, Neck			Endocrine System		
Nose & Sinuses			Spine		
Mouth & Throat			Neurological		
Teeth			Genitalia		
Lungs & Chest			Breasts		
Heart			Pelvic if indicated		
Vascular System			Hernia		
Mental Status					

9. Are there any known mental or physical health problems that would affect progress in the nursing program or participation in clinical nursing activities?
 No () Yes () If yes, please specify on back of form
10. Are there allergies that could be exacerbated by clinical environment or activities?
 No () Yes ()

TO MY KNOWLEDGE, THE INFORMATION I HAVE SUPPLIED ON THIS HEALTH FORM IS ACCURATE AND COMPLETE

 Signature of Physician or Certified Registered Nurse Practitioner

 Date

Please print or type provider's name _____

Medical Office Address Sticker or Stamp Required _____

Student to return form via student tracking system included in acceptance packet within two weeks of receipt.