Name:_____ ID:_____

Jacksonville State University
Lurleen B. Wallace College of Nursing and Health Sciences
Annual Health Appraisal Form

Required Testing

- Tuberculosis Screening (annual)
- Tdap (one time)
- One time Proof of varicella immunity (documented proof of history of disease, titer or vaccination)

This annual health appraisal must be completed prior to the first day of class for all upper division nursing students and/or faculty.

You will not be allowed to matriculate and/or participate in clinical activities until verification of the completed medical form has been received by the College of Nursing.

Health History Report

Information may not be released to a third party unless a proper acceptable authorization is furnished. This release must comply with State and Federal Regulations. Incomplete or inaccurate information may delay your clearance, cancel your registration, or cause improper decision of your future medical care.

General Information
(To be completed by client)

Name: _____ _____ _____ Social Security # _ _ _ - _ _ - _ _ _ _
Last *First* *Middle*

Date of Birth:_____/_____/_____ Age: _____ Sex: (circle) M F

International Student: Yes No If Yes, what country? _____

Permanent Address: _____ _____
Street or P.O Box *City* *State* *Zip Code*

Local Address: _____
Street or P.O Box *City* *State* *Zip Code*

Telephone number: (____) _____ Cell: (____) _____ Work: (____) _____

Emergency Contact- Name_____Relationship_____Number_____

Physical Examination
(To be completed by Health Care Professional)

Height _____Weight _____lbs Temp _____ Pulse _____RR_____ B/P _____

Vision: Corrected Right 20/____ Left 20/____ Contact lenses: Yes___ No ____Glasses: Yes____ No____
Uncorrected Right 20/____ Left 20/____ Ears: Is hearing normal? Yes ____ No ____

Do you have any restrictions on your physical activities? Yes____ No _____ If yes, explain

_____

_____

_____

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At the present time, are you taking any medications regularly, or have you taken any in the past 6 months? Yes____No ____
If yes, please verify medication and dosage.

_____

_____

_____

Is client under treatment for any medical or emotional condition? Yes _____ No____ If yes, explain.

_____

_____

Would you like a referral to the JSU Counseling Center regarding the mental health resources on campus? Yes___ No____

Are there any existing or past abnormalities or conditions that might affect your health adversely during the nursing affiliation?
No ___ Yes ___ If yes, please explain.

_____

_____

Disease	**Primary Vaccine** (MM/DD/YY)	**Booster Vaccine** (MM/DD/YY)	**Serology Date/Results in lieu of vaccination proof**		
Disease	**Vaccine** (MM/DD/YY)	**Vaccine** (MM/DD/YY)			
Tdap (Give if Td booster has not been received in the last two years) If Td booster has been given in the last two years, specify date. Tdap is not required.					
Disease	**Vaccine Date** (MM/DD/YY)	**Vaccine Date** (MM/DD/YY)	**Vaccine Date** (MM/DD/YY)	**Serology Date/Results in lieu of disease documentation**	
Varicella 2 doses or VZV IgG				VZV IgG	
Recommended (Optional)					
Meningococcal					
Influenza ** Highly recommended					
	Placement Date (MM/DD/YY)	Date Read (48-72 hours) (MM/DD/YY)	Result in mm	CXR date needed for positive test	CXR Result
TB Test (**Must be given in the United States**) Can be read by a designated JSU faculty member					
CXR Report					
Referral to County Health Department	Yes NO	PPD > 5mm Yes No	TB high risk protocol recommended Yes No	Treatment Initiated Refused	Treatment Completed Yes No

Name:_____ ID:_____

The client was examined on _____ and **was found** to be physically, mentally and emotionally healthy and **is released** to participate in all patient care activities, including activities requiring patient interaction in the medical setting.
Additional comments/concerns:

The client was examined on _____ and **was not found** to be physically, mentally and/or emotionally healthy and **is not released** to participate in all patient care activities, including activities requiring patient interaction in the medical setting.
Additional comments/concerns:

_____ _____
Print name of Physician/Physician Assistant/Nurse Practitioner Office Address

_____

_____ _____
Signature of Physician/Physician Assistant/Nurse Practitioner Date

_____
Office Phone Number

_____
Signature of client Date