America School of Nursing & Allied Health
Physical Health Forms

Name of student _____Date: _____
Date of birth: _____ Weight: _____ Height: _____

Vital signs: _____

Allergies to medications? Yes No (If yes, please list)

Food allergy? Yes No (If yes, please list)

Environmental allergy? Yes No (If yes, please list)

Past medical, surgical procedures & psychiatric conditions:

_____
_____ _____

_____

Has student had any ongoing health problem that would interfere with performance in tasks, or pose a risk in clinical nursing settings? □ Yes □ No (If yes explain)

_____
_____
_____

List Medications (prescribed, or over-the-counter)?

_____

_____

Any disabilities: □ Yes □ No State nature:

_____
_____
_____

Smoking: □ Yes □ No Type:

_____

Drug/alcohol use: □ Yes □ No Type:

_____
_____

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Clinical Evaluation	Normal	Abnormal	Comments
Neurologic			
Skin			
Head			
Ears/Hearing			
Eyes/Visual acuity			
Mouth, teeth and gums			
Neck and thyroid			
Heart			
Chest/Lungs			
Breast			
Abdomen			
Genitalia			
Back/Spine			
Extremities/Musculoskeletal/Femoral Pulses			
Emotional/Physiological status			

Examining Practitioner's Statement: I have obtained a history, discussed, reviewed the systems, and performed a physical examination on the above-named student. To the best of my knowledge, the above-named is in good physical and mental health and is free from a health impairment, including a substance abuse problem, which is of potential risk to other students, or which might interfere with the performance of the student's duties in the nursing program.

Examining Practitioner's Signature: _____

Examining Practitioner's Printed Name: _____

Address: _____

Telephone (_____) _____ Fax (_____) _____

Today's Date: _____/_____/_____Official Stamp (if available):

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Immunizations/Vaccines

NOTE: If student has Immunizations from the past, please provide it to the school.
If you have taken immunizations before and you cannot locate your records please go to a nearby clinic, hospital or personal physician and have a titer of the immunizations/Vaccines performed again.

PPD/Mantoux (Required once every year)
Date Placed_____ Time _____ Date Read_____ Time_____
Results: _____mm _____Positive _____ Negative

[ ] History of past positive PPD: Date of latest chest X-ray _____/_____/_____
Results of X-ray_____
(Signature and title): _____

MMR (proof of immunization is required for individuals born after 1/1/1957)
Measles
[ ] Titer: Date: _____/_____/_____ Results _____
Or
[ ] Vaccine: Date: _____/_____/_____
Date of 1st dose _____/_____/_____ **and** Date of 2nd dose _____/_____/_____

Mumps (must be documented by positive titer or date of vaccination)
[ ] Titer: Date: _____/_____/_____ Results _____
Or
[ ] Vaccine: Date: _____/_____/_____

Rubella (must be documented by positive titer or date of vaccination)
[ ] Titer: Date: _____/_____/_____ Results _____
Or
[ ] Vaccine: Date: _____/_____/_____

Varicella Zoster /Smallpox Vaccine:
[ ] Vaccine: Date: ____/____/_____ [ ] Initial vaccine: Date: ____/____/_____
Or
[ ]: Date of disease (month & year)____/____/_____

[ ] Positive antibody titer: Contraindications: _____
Date ____/____/_____

Hepatitis B
[ ] Hepatitis B Antibody Titer: Date: ____/____/_____
Or
[ ] Initial vaccine: Date: ____/____/_____ 2nd Dose___/____/_____ 3rd Dose___/____/_____

DIPHTHERIA-TETANUS (Td) OR MENINGITIS (Age 22 and less):
PERTUSIS (Tdap): Date of booster: _____ **Date of vaccination:** _____

FLU VACCINE: Date of vaccination: _____

Practitioner's Signature: _____
Practitioner's Printed Name_____
Address_____
Telephone (_____) _____ Fax (_____) _____
Today's Date: _____/_____/_____ Official Stamp (if available):