

**GEORGIA SOUTHERN UNIVERSITY
SCHOOL OF NURSING**

Health History Form

Last name **First name** **Middle** **ID #**

Date of Birth: _____ **Sex:** M F **Marital Status:** S M

Please answer the following questions and provide an explanation for any "Yes" answers.

Do you now have or have you had:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Eye or vision problems:	___	___	Hepatitis:	___	___
Ear or hearing trouble:	___	___	Tuberculosis:	___	___
Severe headaches:	___	___	Bone/joint problems:	___	___
Epilepsy/convulsions:	___	___	Anemia:	___	___
Asthma:	___	___	Diabetes:	___	___
High blood pressure:	___	___	Mental health problems	___	___
Heart problems:	___	___	Other health problems:	___	___

Attach health care provider summary regarding any "yes" answers.

Hospitalizations, injuries, or operations: _____

Physical disabilities (describe): _____

Medications that you take regularly:

Medication: **Reason taken:** **Health provider ordering:**

Allergies to medications, insect bites, foods, or other substances (give details):

I certify that the information contained on this form is true and correct. I understand that misrepresentation or omission of information will be sufficient grounds for dismissal from the BSN Program.

Student Signature

Date

GEORGIA SOUTHERN UNIVERSITY SCHOOL OF NURSING
BSN Program Admission Physical Examination Form

Student Name _____ ID No. _____

DATE: _____ PHYSICAL EXAM _____																	
BP _____			P _____			HT _____			WT _____			Hgb/Hct _____			U/A _____		
Normal	Yes	No	Normal	Yes	No	Normal	Yes	No	Normal	Yes	No	Normal	Yes	No			
SKIN			LUNGS			MUSCULO-SKELETAL:			NEUROLOGIC:								
EENT			HEART			MUSCLE STRENGTH			MENTAL STATUS								
MOUTH			BREASTS			GAIT			SPEECH								
THYROID			ABDOMEN			EXTREMITIES			MOTOR								
CHEST			GENITALIA			SPINE			SENSORY								

ABNORMAL/ SIGNIFICANT FINDINGS:

Visual Acuity: (Required) Snellen _____ Titmus _____ L _____ R _____ With Correction: L _____ R _____	Hearing Screening: (Required) Audiogram _____ L _____ R _____ With Correction: L _____ R _____
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Examiner's Signature	Title	Date
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Print or type name and address of health care provider:

Examiner's name _____ Title _____

Address _____

City _____ State _____ Zip _____ Phone _____

Department of Nursing Reviewer _____	
Date _____	Recommendation _____

**GEORGIA SOUTHERN UNIVERSITY
SCHOOL OF NURSING - IMMUNIZATION FORM**

Student Name _____ **Date of Birth** _____ **ID #** _____

School of Nursing Required Immunizations or Tests:
(Must be completed prior to enrollment in the first nursing course)

Tuberculin Skin Test (PPD) Date: _____ Result: _____

Provider Signature _____ Title _____

Agency _____

Chest x-ray required if PPD is positive* Date: _____ Result _____

*Attach summary from health care provider regarding follow-up of any positive PPD.

Evidence of Immunity to Rubella

Rubella titer (all students)* Date: _____ Result _____ **Attach Lab Slip**

*Health Care agencies require evidence of immunity to Rubella for all students. If the rubella titer is negative, a follow-up dose of rubella vaccine must be given.

Follow-up rubella vaccine _____ Date: _____

Hepatitis B

Dose #1 Date: _____ Provider Initials _____ Agency _____

Dose #2 Date: _____ Provider Initials _____ Agency _____

Dose #3 Date: _____ Provider Initials _____ Agency _____

or Immune titer Date: _____ Result _____

or Vaccine refusal Date: _____ **Attach Form**

Waiver form for incomplete series Date: _____ **Attach Form**

MMR (Measles, Mumps, Rubella) Booster, if born after 1957 or laboratory evidence of immunity to measles and rubella:

and Dose 1 - immunized at 12 months of age or later Date: _____

Dose 2 - immunized at least 30 days after Dose 1 Date: _____

Print or type name and address of health care provider completing this form.

Name _____ Address _____ Title _____

City/Town _____ State _____ Zip _____ Phone _____

Immunization status above is certified by:

Signature of Health Care Provider _____ Date Signed _____

**Georgia Southern University
School of Nursing
BSN Program**

Varicella (Chicken Pox) History Form

Chicken pox (varicella) is now a vaccine-preventable disease. Chicken pox can be a serious and even life threatening illness in certain individuals. Several hospitals and clinical agencies with whom the Department of Nursing is affiliated for clinical experiences now require that we furnish documentation of a history of chicken pox (varicella) immunity. Varicella vaccination is now recommended for health care workers who have not had the chicken pox or who are susceptible to getting the chicken pox (unless there is a medical contraindication).ⁱ For these reasons we are now asking our nursing students to furnish us this information and recommending that those students who have a negative or uncertain history of chicken pox receive testing and vaccination if needed.

___ I have had the chicken pox. Approximate date: _____

___ I have not had the chicken pox or am uncertain as to whether I have had the chicken pox.ⁱⁱ

___ I have been immunized against chicken pox. Dates: _____

I certify that the above information is correct.

Name: _____ Date: _____
Please print

Signature

¹ Centers for Disease Control (CDC) (1997, May 16). Morbidity and Mortality Weekly Report, 46, 409-412.

² For adults with a negative or uncertain history of chicken pox, a blood test to determine susceptibility to chicken pox is suggested followed by vaccination of those who are susceptible (CDC).

**GEORGIA SOUTHERN UNIVERSITY
SCHOOL OF NURSING**

HEPATITIS B VACCINE REFUSAL FORM

I understand that as a part of my clinical experiences as a nursing student, I may be exposed to blood or other potentially infectious materials and that, as a result, I may be at risk of being infected by the Hepatitis B virus. I understand that Hepatitis B is a severe and potentially life threatening illness and that taking the series of three vaccinations would significantly reduce my risk of being infected by the Hepatitis B virus. Nevertheless, I elect not to take the required series of vaccinations and assume responsibility for all arrangements, costs, and complications arising from not taking the hepatitis B vaccine series. I also understand that if the hospital or clinical agency where I have been assigned for my clinical requires students to be immunized for Hepatitis B, the School of Nursing assumes no responsibility for reassigning me to another clinical agency and therefore I will not be able to take the required course.

Print your full name: _____

Signature **Date**

WAIVER FORM FOR INCOMPLETE HEPATITIS B VACCINE SERIES:

I have started, but not completed the Hepatitis B Vaccine Series. I understand that as a part of my clinical experiences as a student in the Georgia Southern University School of Nursing, I may be exposed to blood or other potentially infectious materials and therefore may be at risk of being infected by the Hepatitis B virus. I understand that this waiver is valid only until the date that my series is complete. I agree to provide the School of Nursing with immunization verification immediately upon completion of the series.

I have received the following doses of the Hepatitis B vaccine:

Dose 1: **Date** _____
Dose 2: **Date:** _____

Print your full name: _____

Signature: _____ **Date:** _____

**GEORGIA SOUTHERN UNIVERSITY
SCHOOL OF NURSING
Clinical Course Renewal Form**

Student Name _____ **Date of Birth** _____ **ID#** _____

School of Nursing Clinical Course Requirements:

1. **Tuberculin Skin Test (PPD)** Date: _____
Result: _____

Chest x-ray, required if PPD is positive* Date: _____
Result: _____

*Attach summary from health care provider regarding follow-up of any positive PPD.

2. **Current CPR:** Expiration Date: _____
Type: (AHA Provider Level) _____

Attach copy of **CPR** card with expiration date.

3. **Liability Insurance:**

a.) Individual policy* expiration date: _____
*Attach copy of policy cover sheet showing amount and expiration date.(RN-BSN students)

b.) Group policy holder* (BSN only): _____
A charge will be included with the tuition invoice to cover the Maginnis and Associates Student Malpractice Blanket Liability Insurance Program (which is carried by the School of Nursing)

4. If licensed: Current license number, state of licensure and expiration date

Print or type name and address of health care provider completing PPD or chest x-ray.

Name	Address	Title
City or Town	State	Zip
		Phone Number (____) _____

Immunization status above is certified by:

Signature of Health Care Provider	Date Signed
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