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

The individual named below is a student in the College of Nursing and Health Sciences. Your cooperation in performing the annual health examination and completing this form will assist both the student and the College.

Name: _____ Date of birth:_____

Address: _____ Student ID: _____ Phone:_____

City: _____ State:_____ Zip: _____

In an emergency notify: _____ Phone:_____

Physical Examination:

Height	Weight	Blood Pressure	Pulse	Glasses Contacts

Check the appropriate box. Explain abnormal findings below.

	Normal	*Abnormal*		*Normal*	*Abnormal*		*Normal*	*Abnormal*
Head	☐	☐	Neuro	☐	☐	Abdomen	☐	☐
Eyes	☐	☐	Thyroid	☐	☐	Extremities	☐	☐
Ears	☐	☐	Chest	☐	☐	Skin	☐	☐
Nose	☐	☐	Lungs	☐	☐	Breasts	☐	☐
Throat	☐	☐	Heart	☐	☐	Genital (If clinical indicated).	☐	☐

_____

_____

Are there any existing or past abnormalities or conditions that might affect his/her health adversely during the nursing affiliation? No☐ Yes☐ please explain

_____

_____

Are there any existing or past abnormalities or conditions that might affect his/her ability to function in a health care agency? No☐ Yes☐ please explain

_____

_____

Please attach additional sheets of paper if needed to describe abnormal conditions.

_____ _____

MD, NP or PA Signature❋ **Date**

_____ _____

MD, NP or PA Signature Printed Name **Name of Provider's Practice/Agency/Organization**

_____

Address **City** **State** **Zip**

over

❋Cannot be signed by a RN or MD's office personnel.

Name:_____ Student ID**:** _____

Cannot be signed by a RN or MD's office personnel.

Required: PPD Mantoux Tuberculin Skin Test (Tine Test NOT acceptable)

Must be administered no earlier than 6 weeks prior to physical exam.
The test **must be read in 48-72 hours** after administration.

Date Given	Date Read	Result	MD, NP or PA Signature or Official Clinic Stamp Only✱	Date

If the student had a positive PPD TB test in the past or if BCG vaccine was received, a negative chest x-ray report is required.

☐ Chest x-ray of _____ was within normal limits and showed no evidence of infection.
Date

Physician's recommendation is required for follow-up evaluations after an initial negative chest x-ray:

☐ Needs no further chest x-ray, unless student becomes symptomatic with a respiratory disease.

☐ Needs yearly chest x-ray.

☐ Other, explain:_____

MD, NP or PA Signature or Official Clinic Stamp Only✱ Date

✱Cannot be signed by a RN or MD's office personnel.