



Student Health Form

Section I - To be completed by the student

Last Name	First Name	Middle Initial	Maiden Name
Address	City	State	Zip Code
Telephone ()	Date of Birth	Class <input type="checkbox"/> Freshman <input type="checkbox"/> Junior <input type="checkbox"/> Sophomore <input type="checkbox"/> Senior	SSN
Physician Name (In Case of Emergency)		Physician Address	Physician Phone

Health History

Allergies (Latex, Drug, Food, etc.)
--

Medications	Dosage	Frequency	Reason

List any Medical History or Conditions the College needs to be aware of (i.e.: Physical Limitations):

Health History (Continued)

Have you ever had been treated for or are you currently being treated for any of the following:

	Yes	No	Date	Treatment/Comments
Cardiovascular				
High Blood Pressure (Hypertension)				
Heart Disease or Chest Pain				
Heart Murmur				
Blood Disorder				
Digestive				
Stomach Disorders				
Frequent Nausea/Vomiting				
Frequent Diarrhea				
Difficulty Swallowing				
Genitourinary				
Frequent Urinary Tract Infections				
Kidney Disease				
Head & Neck				
Headaches (Frequent or Severe)				
Sinus Problems				
Neurological				
Seizure Disorder				
Fainting Spells				
Multiple Sclerosis				
Parkinson's Disease				
Polio or Paralysis				
Balance Difficulties				
Respiratory				
Asthma				
Tuberculosis				
Emphysema				

	Yes	No	Date	Treatment/Comments
Chronic Respiratory Problems				
General				
AIDS/HIV Positive				
Arthritis				
Cancer				
Diabetes				
Hepatitis				
Hernia				
Mental Health/Emotional Problems				
Stroke				
Substance Abuse or Dependence (Alcohol, Drugs, etc.)				
Thyroid Problems				
Other				
Chicken Pox				
Measles				
Mumps				
Rubella				

Have you ever been diagnosed with a learning disability? Yes No If Yes, please explain:

Have you had any significant operations, hospitalizations, or accidents not already disclosed?

I certify that my statements and answers are complete and true to the best of my knowledge.

Student's Signature

Date

Section II - To be completed by the examiner

The following information must be updated yearly and on file at the college while this student is attending the Columbia College/Mount Mary College of Nursing Program.

Immunizations		
Tetanus	MMR (Measles, Mumps, Rubella)	Varicella Titre
Date:	Date:	
TB Skin Test (or PPD)		Circle One:
Date of Test:	Date of Results:	Results: POS NEG
Hepatitis B Series		(Series must be started by sophomore year)
Dose 1 Date:	Dose 2 Date:	Dose 3 Date:

Lab Results				
Hemoglobin		Hematocrit		
Date:	Results:	Date:	Results:	
Urinalysis	Date:	Albumin:	Sugar:	Micro:
Circle One				
POS	NEG			

Physical Exam				
Height:		Weight:		
Blood Pressure:		Pulse:		
(R) Arm:	(L) Arm:			
Vision:	Date:	Circle One:	Glasses	Contact Lenses
Right Eye: (Uncorrected)	Left Eye: (Uncorrected)	Full Spectrum of Color:		
Hearing:	Date:	Use Hearing Devices?		
Right Ear:	Left Ear:	Yes	No	

Does this individual have any condition that would impair physical function or mobility? If yes, please explain.

Do you have any concerns regarding the ability of this individual to meet the requirements of a professional nursing program? If yes, please explain:

I have examined this individual and certify the above information to be complete and accurate.

Signature of Physician

Date

Address

City

State

Zip Code

Telephone

Every item must be completed to avoid this form being returned to you.

Return completed health form to:

Columbia College of Nursing
Office of Student Services
2121 E. Newport Avenue
Milwaukee, WI 53211
(414) 961-4131