



Morris County Vocational School District
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LICENSED PRACTICAL NURSING PROGRAM
 Health Assessment and History Form (DUE NO LATER THAN August 24, 2017)

Name (Last, First, Middle Initial) _____

Date of Birth _____ Age _____ Gender _____

Address _____

Emergency Contact Name _____ Emergency Contact Number _____

Section 1: Health History (To Be Completed by Student)

Do you NOW have or have you EVER had any of the following:

Night Sweats or Fever	High Blood Pressure	Thyroid Problems
Recent Weight Gain/Loss	High Cholesterol	Kidney Infection
Convulsions/Seizures/Epilepsy	Murmur	Liver Disease
Fatigue	Swollen Ankle/Feet	Jaundice
Numbness/Tingling/Weakness	Tuberculosis	Cancer
Fainting/Dizzy Spells	Shortness of Breath	Hernia
Headaches	Asthma	Diabetes
Paralysis	Bronchitis	Stroke/Blood Clot
Color Blind	Pneumonia	Persistent Cough
Stomach or Bowel Problems	Arthritis	Vision Problems
Mouth Sores	Back Trouble/Pain	Hearing Problems
Sinus Problems	Hepatitis	Joint Pain/Injury
Chronic/Frequent Colds	Skin Disease	Fracture/Broken Bones
Chest Pain	Heart Problems	Blood Disorder
Hypoglycemia	Mononucleosis	Menstrual Disorder

Please list any of the following:

Allergies	Surgeries (Type & Date)	Medications (Including Vitamins, Mineral Supplements, Over the Counter, Etc.)

This record will become part of the student's LPN Program file and disclosed to school officials with the legitimate interest.

I hereby represent that each answer to a question herein and all other information otherwise furnished is true and correct, constituting a full and complete disclosure of my knowledge with respect to the question or subject to which the answer or information relates. I understand that any incorrect or false statements or information furnished by me will subject me to disqualification at any time.

Student Signature _____

Date _____



Section 2: Health Care Provider's Examination (To Be Completed by HCP Only)

Height _____ Weight _____ Temperature _____ Blood Pressure _____ Heart Rate _____

Vision R _____ L _____ (corrected or uncorrected) Hearing _____ (whisper test acceptable)

System	Satisfactory	Unsatisfactory	Problem Explained
HEENT			
Lymphatic			
Respiratory			
Cardiovascular			
Abdominal			
Genitourinary			
Musculoskeletal			
Skin			
Neurological & Reflex			

General Impression/Health: Good _____ Fair _____ Poor _____

Remarks and Recommendations:

ATTACH LAB RESULTS FOR TITERS: Varicella, Measles/Rubella, Mumps, Rubeola, Hep B
Labs with results of titers are required; a positive history of disease is not acceptable documentation for the nursing program.

Dates of Immunizations: If non-immune titers resulted.

MMR # 1 _____ MMR # 2 _____

Varicella _____ Hep B # 1 _____ # 2 _____ # 3 _____

Mantoux (Required yearly for all nursing students in clinical rotations)

#1: Date _____ Site: L or R Forearm Result _____

#2: Date _____ Site: L or R Forearm Result _____

If Mantoux is positive at time of reading, a CXR must be done and the report attached with this form.

If student has history of previous positive Mantoux, include last CXR report (must be within 5 years) and/or treatment report.

Tetanus Booster or TDAP Vaccine / Date Administered _____

FLU Shot is MANDATORY / Date Administered _____

Are there any emotional problems the school should be aware of in order to assist the student in achieving his/her educational goal?

Healthcare Provider's Name _____

Date _____