Morris County Vocational School District
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LICENSED PRACTICAL NURSING PROGRAM
Health Assessment and History Form (**DUE NO LATER THAN August 15th, 2018**)

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**		**Join 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 _____