

**ROXBOROUGH MEMORIAL HOSPITAL  
SCHOOL OF NURSING**

**HEALTHCARE FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

In case of illness, notify: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tel.: \_\_\_\_\_ Relationship: \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

Heart Disease: \_\_\_\_\_ Diabetes: \_\_\_\_\_  
 Epilepsy/Seizure Disorder: \_\_\_\_\_ TB: \_\_\_\_\_  
 Other: \_\_\_\_\_

**STUDENT HEALTH HISTORY:**

Accidents/Injuries/Fractures: \_\_\_\_\_  
 \_\_\_\_\_  
 Surgery/Hospitalization: \_\_\_\_\_  
 \_\_\_\_\_

Health Conditions: \_\_\_\_\_  
 \_\_\_\_\_

Smoker \_\_\_\_\_ Amount \_\_\_\_\_

LMP \_\_\_\_\_ Date Mammogram \_\_\_\_\_ Date GYN Exam \_\_\_\_\_

Present Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Other: \_\_\_\_\_

**HISTORY COMMUNICABLE DISEASES**

Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_ TB \_\_\_\_\_

Hepatitis \_\_\_\_\_ Rubella \_\_\_\_\_

**IMMUNIZATION HISTORY DATES:**

Tdap \_\_\_\_\_ MMR \_\_\_\_\_ PPD \_\_\_\_\_ Hepatitis B \_\_\_\_\_

The above statements are true and correctly rendered:

SIGNATURE OF STUDENT: \_\_\_\_\_

**HISTORY: PLEASE LIST ALL PERTINENT MEDICAL CONDITIONS AND MEDICATIONS APPLICANT IS TAKING.**

<b>1. General Appearance</b>			
<b>2. Temp</b>	<b>3. Pulse</b>	<b>4. Blood Pressure</b>	<b>5. Height</b>
		s.	ft. inches
		d.	lbs.
<b>7. Eyes</b>	<b>Jaeger</b>		<b>Color Vision</b>
Uncorrected <u>Rt. Lt.</u>	Corrected <u>Rt. Lt.</u>	<u>Corrected Uncorrected</u> <u>Rt. Lt. Rt. Lt.</u>	
<b>8. Allergies</b>		<b>9. Ears</b>	<b>Nose</b>
<b>10. Oral Cavity</b>	<b>11. Neck</b>	<b>12. Chest</b>	<b>13. Breast</b>
<b>14. Heart</b>	<b>15. Abdomen</b>	<b>16. Hernia</b>	<b>17. Genito-Anal</b>
<b>18. Skin</b>	<b>19. Endocrine</b>	<b>20. Lymph</b>	<b>21. Extremities</b>
<b>22. Blood Vessels</b>	<b>23. Neurological</b>	<b>24. Psychiatric</b>	

**\*\*\*ATTENTION MEDICAL PERSONNEL\*\*\* FORMS WILL NOT BE ACCEPTED WITHOUT COPIES OF THESE STUDIES**

Please include copies of the following required studies

CBC

Urinalysis

Serology (RPR)

Rubella Titer

Rubeola Titer

Varicella Titer (if negative history of Chicken Pox or unsure of history)

HbSAG or HBSAB (if had vaccine)

PPD

Chest x-ray if history of +TB test in past

Tdap

---

Remarks and Recommendations:

This student is free of active communicable disease and is able to perform the required duties.

---

Address

---

Healthcare Provider

---

Telephone

---

Print Name

***Please return this completed form along with copies of bloodwork to: P.E. Burke, Roxborough Memorial Hospital School of Nursing, 5800 Ridge Avenue, Philadelphia, PA 19128***