

**LANCASTER GENERAL COLLEGE OF NURSING AND HEALTH SCIENCES
HEALTH ASSESSMENT
BS in Nursing/Health Sciences**

****This form must be completed prior to the start of HSC 302 or NUR 302**

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Program of Study: _____

Proof of Immunity: (titers must be within the past five years)

Mumps: _____

Hepatitis B Antibody: _____

Rubella: _____

OR: Dates of Hep B immunizations:

Rubeola: _____

1)_____ 2)_____ 3)_____

Varicella: _____

Tetanus: _____ (last 10 years)

Medical History: (please list any significant allergies, medications or medical issues which you feel the Health Center should know about)

Systems Review

SYSTEM	WNL	COMMENTS
HEENT		Date Completed: -----
Skin		
Cardiovascular		
Respiratory		
Abdomen		
Musculoskeletal		
Neurological		
Genitourinary		
Breasts		
PPD Test:	Date applied: Date read: Result:	If positive, date of CXR: Results of x-ray: Isoniazid Prophylaxis? Yes ____ Date: No ____ PHYSICIAN/NP/PA SIGNATURE _____