06/2010

Armstrong Atlantic State University
Graduate Program in Nursing
Application for Admission
Student Health Appraisal Form

Name: ______________________________________ 907________________
(last) (first) MI

Date of Birth: ______________________ Race: _____________ Sex: _____________

List any Serious Illnesses: ____

____

List any Surgeries (include date, operation and physician): ___________________________

____

Did any of these illnesses or surgeries cause permanent damage? [ ] Yes [ ] No

If "yes", explain ____

____

Disabilities ____

____

Physical Aids (Crutches, Braces, Prosthesis) ____________________________________

____

List any medications you take regularly		
Medication	**Reason Taken**	**Physician Ordering**

Family Health History (List any serious illnesses in your family)

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______________________________________ ___________________________

Student Signature Date

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Student Health Appraisal Form

Physical Examination (To be completed by a physician or nurse practitioner)

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Tests

Blood Pressure__________	Pulse________	Height_________	Weight________
Hgb/Hct________/________	U/A________		

Comments: ____

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PPD	Date	Results
Chest X-Ray, if indicated	Date	Results
Hepatitis B Core Titer	Date	Results
Rubella Titer	Date	Results
* If non-immune – Vaccination Date		
MMR Vaccination	Dates Given	
	Vaccination #1 ____________ Age ______	
	Vaccination #2 ____________ Age ______	

Comments: ____

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Examiner's Signature ________________________ Date ___________________

Please return form to Graduate Enrollment Services, Armstrong Atlantic State University,
Victor Hall 2nd Floor, 11935 Abercorn Street, Savannah, GA, 31419-1997.
Telephone 912.344.2798, Fax 912.344.3488, E-mail: Graduate@armstrong.edu