ADMISSION HEALTH RECORD
MISSISSIPPI COLLEGE SCHOOL OF NURSING
Box 4037, Clinton, MS 39058

Good health is important to your nursing career. We ask that you carefully complete the history and the information section of this examination in order to help the examiner to ascertain your correct health status. This form must be completed and returned to the School of Nursing as a part of the admission procedure.

STUDENT COMPLETES ALL ITEMS ON THIS SIDE

Name _____ Social Security No. _____
Last First Middle

Address _____
Number and Street City State Zip Code

Parents/Spouse _____ Address _____

Person to be notified in event of serious accident or illness:

Name _____ Address _____ Phone _____
Relationship

Family physician _____ Address _____ Phone _____

FAMILY HISTORY: Circle and fill in as indicated.

Father: Occupation _____ If deceased, cause of death _____

Mother: Occupation _____ If deceased, cause of death _____

Have any of your parents, sisters, brothers, children or your spouse suffered from: diabetes/epilepsy/tuberculosis/mental illness/cancer?

Yes _____ No _____ Identify & Explain _____

PERSONAL HISTORY: Have you now or have you ever had any of the following? If yes, please explain on an attached sheet of paper. Include medications.

	Y	N		Y	N		Y	N		Y	N
Allergy			Diseases ears			Fractures			Mental illness		
Appendicitis			Diseases eyes			Habitual constipation			Mumps		
Arthritis or Rheumatism			Diseases heart			Headache			Paralysis		
Asthma			Diseases intestines			Heart condition			Pneumonia		
Bronchitis			Diseases liver or gall bladder			Hepatitis			Pregnancy		
Cancer			Diseases lungs			High blood pressure			Rheumatic fever		
Chicken pox			Diseases sexual organs			Jaundice			Scarlet fever		
Chronic Cough			Diseases skin			Malaria			Smallpox		
Deformities			Diseases stomach			Measles (red) rubella			Syphilis		
Diabetes			Drug misuse/addiction			Measles (3 day) rubella			Tuberculosis		
Diseases urinary-bladder or kidneys			Epilepsy			Meningitis			Typhoid fever		
Diseases brain or spine			Fainting spells			Menstrual difficulties					

Name any serious diseases or injuries not listed above that you have had and when you had them. _____

_____

List hospitalizations and surgical procedures. Give dates & reasons for each (use attached sheet if necessary):

IMMUNIZATION HISTORY	DATE OF IMMUNIZATION/BOOSTER/TITER
OPT (must have tetanus booster within 10 yrs)	
Polio Vaccine	
MMR (Measles/Mumps/Rubella)	
Hepatitis B Vaccine	

Have you ever been hospitalized? _____ When? _____ For What? _____

Do you have any physical/mental limitations? _____ If yes, please explain on separate sheet and identify specific needs.

Do you have any chronic illnesses? _____ Explain _____

Are you taking any medication, i.e., insulin, dilantin, allergy injections, special diet, etc? _____ If yes, give complete information

_____

Are you allergic to any food, drugs, medicines, serum, etc? _____ Explain _____

State current exercise limitations (if any) _____

I certify that the above information is complete to the best of my knowledge. I understand that falsification of the information may result in dismissal from the school.

Date _____ Signature _____

Mississippi College School of Nursing
Box 4037, Clinton, MS 39058
ANNUAL PHYSICAL EXAMINATION

(To be completed by physician/nurse practitioner. Physical examinations performed within the last 6 months are acceptable.)
Name _____ Age _____
(Please PRINT or TYPE)
Height _____ Weight _____ Recent change _____ Temp. _____ Pulse (sitting) _____
Blood pressure (sitting) _____ Hearing-Right Ear _____ Left Ear _____
Vision-Right Eye _____ Left Eye _____ Corrected-Right Eye _____ Left Eye _____
Nutritional Status _____

Normal	Abnormal	Check each item in appropriate column. Enter N.E., if not evaluated.	NOTE: Comment in this column on abnormalities.
		Head, face, scalp	
		Neck, nodes, thyroid	
		Nose and sinuses	
		Mouth and teeth	
		Pharynx and tonsils	
		Ears	
		Eyes	
		Lungs	
		Thorax, breasts	
		Heart	
		Abdomen, hernia, scars	
		Anus and rectum	
		Endocrine system	
		G.U. system	
		Extremities and feet	
		Spine and musculoskeletal	
		Reflexes	
		Skin	
		Neurologic	
		Psychiatric evaluation	
		Lymphatic system	
		Vascular system	

NOTE: the lab work below needs to be completed by the health department or the physician when the exam is given. Date of tests_____
Urinalysis: Albumin _____ Sugar_____ Microscopic _____
Hemoglobin _____ Hct. _____ Results of other tests if indicated:_____
RPR_____

Tuberculin 2-step* (if results positive, CXR required): Date_____ Results_____ Date_____ Results____
*Then Annual may be done Date_____ Results_____

Is there any reason why this student cannot participate in physical education? Yes ☐ No ☐

Is there any reason this student should not live in the dormitory? Yes ☐ No ☐

Conclusion: (Please comment on any serious condition of any continuing therapy.) _____
_____

Type or PRINT Name & address of physician/practitioner:
_____ Signature_____
_____ Date_____