

Nursing Student Annual Health Update

Student Health Services
4245 East Avenue
Rochester, NY 14618
(585) 389-2500
Fax: (585) 389-2503

Please complete this form & return to Student Health Services. Please print!

Name: _____ Date of Birth: _____

Cell Phone: _____

1. Please list all physical and/or mental health conditions _____

2. Please list all allergies to medications, foods, latex, etc. _____

3. Please list all medications that you take regularly:

4. Have you been hospitalized in the previous year? Yes ___ No ___ *If yes, please list date and reason:*

5. Do you have any condition that would interfere with your ability to participate in a clinical setting or that would be a risk to others? Yes ___ No ___ *If yes, please explain:*

6. Do you have limitations on physical activity? Yes ___ No ___ *If yes, please explain:*

7. Have you had chicken pox? Yes ___ No ___
If no, dates of varicella vaccine 1. _____ 2. _____
8. Please indicate if during the last year you have had any of the following symptoms for four weeks or longer:

Yes	No	
		A prolonged fever
		Chills or night sweats
		Chest pain
		A productive cough
		Unexplained weight loss
		Loss of appetite
		Undue fatigue
		Blood tinged sputum

I certify that my responses above are complete and true to the best of my knowledge.

Signature

Date

Office Use Only:

Signature

Date

Comments: _____