Minnesota State University, Mankato – School of Nursing
Student Health Record

Side 1 – To be completed by student candidate prior to submitting to Primary Health Care Provider
Please print
Name:____ **Phone:**________________________
(Last) (First) (Middle)
Address:____ **City/State/Zip:**__________________
Contact Person/Relative:__________________________ **Phone:**__________________________
Address:____ **City/State/Zip:**__________________

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Medical History						
I have/have had the following:						
	No	**Yes**	**Family History of:**			**Member**
Bone Disease			Cancer			
Chicken Pox (after 1 year of age)			Diabetes			
Hay Fever			Heart Disease			
Ear Infections (Otitis Media)			Kidney Disease			
Heart Disease			Liver Disease			
Joint Disease			Mental Disease			
Gastrointestinal Disease			Nervous System Disease			
Kidney Disease			Tuberculosis			
Liver Disease						
Measles (Rubella)						
Mumps						
Nervousness, Anxiety, Depression						
Pneumonia						
Polio						
Rheumatic Fever						
Scarlet Fever						
Skin Disease						
Tuberculosis						
Whooping Cough (Pertussis)						

Do you have, or have you had the following:	**No**	**Yes**	**Specify/Give Details**
Allergies (medications, food, environmental)			
Injuries			
Major illness or disorder			
Are you on any current medications?			

Significant Data	**No**	**Yes**	**Specify/Give Details**
Has your physical activity been restricted during the past five years? (Give reasons and durations)			
Have you received treatment or counseling for a psychological or emotional disorder? (ie: chemical dependency, eating disorder, depression)			
Have you had any serious illness or injury or been hospitalized other than already noted?			

Family History

Family Member	**Age**	**State of Health**	**If Deceased, Age at Death**	**Cause of Death**
Father				
Mother				
Brothers				
Sisters				

(Side 2)

Report of Physical Examination

Name:____
(Last) (First) (Middle)

Age		Sex		Weight		Height		Temp		BP		Pulse		Resp	

General Appearance:____

Skin		**Breasts**	
Eyes/Vision		**Abdomen**	
Ears/Hearing Acuity		**Genitalia**	
Nose		**Rectal**	
Mouth		**General Nodes**	
Throat		**Spine**	
Neck		**Extremities**	
Heart		**Neurological**	
Lungs		**Mental Status**	
Chest		**Hernias**	

Dates of Immunization:
MMR 1) ____________ 2) ____________
Polio 1) ____________ 2) ____________ 3) ____________ 4) ____________
Hepatitis B 1) ____________ 2) ____________ 3) ____________
DPT 1) ____________ 2) ____________ 3) ____________ 4) ____________ 5) ____________
DT Date of last immunization ____________
Varicella 1) ____________ 2) ____________
If you have had any of these diseases (i.e. mumps, pertussis, chicken pox) please indicate:
Disease Year Disease Year

________________ ______ ________________ ______

Tuberculin (every 6 months)
Date Given ________ Forearm ☐L ☐R ________________ Signature ____________________
Date Read ____________ Result ________ mm Signature ____________________
OR
Chest x-ray Date: ____________ Results ____________________

Note: These immunization dates are required for student activities in patient care/clinical sites.

Summary of History, Previous Diagnoses and Findings:____

____

Comments:____

____

Provider Information:
Name:____ **Phone:**________________
(Last) (First) (Middle)
Agency/Clinic:______________________________________
Address:____ **City/State/Zip:**____________
Signature of Provider:______________________________ **Date:**________________

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Student Verification:

I certify that all of the above information is correct to the best of my knowledge. I understand that medical information is private data and will only be used by School of Nursing faculty and clinical agencies in determining my physical health for nursing. While I am not legally required to provide this information, failure to complete this health record will prevent my being allowed to participate in clinical activities. Permission is hereby granted to Mankato State University School of Nursing to request and receive my medical information with appropriate hospitals/agencies providing clinical experiences/practicums for nursing students.

Signature of Student:____ Date:____________________