



THE UNIVERSITY OF WEST FLORIDA
DEPARTMENT OF NURSING
Statement of Health Form



(Must be completed by a licensed health care provider)

Name: _____ DOB: _____

Local address: _____

Do you have, have you ever had, or are you now receiving treatment for any of the following?

Check yes or no.

	Yes	No		Yes	No
1. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	12. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
2. Ashtma			13. Emotional problems		
3. Tuberculosis/ or other communicable disease			14. Other disease or illness		
4. Heart disease			15. Do you have any illness or medical condition that requires regular treatment?		
5. Polio			16. Do you a disability that you want us to know about?		
6. Chronic Respiratory			17. Is there any reason for restricting your activity?		
7. High Blood Pressure			18. Do you wear contact lenses?		
8. Backache			19. Do you smoke or chew tobacco?		
9. Joint trouble			20. Have you ever smoked or chewed tobacco?		
10. Major surgery or injury			21. Do you have any condition, with, or without accommodation which will impair your ability to meet the essential functions of the Nursing Program?★		
11. Severe headache			★Students answering yes to question # 21, please contact the Student Disability Resource Center at 850-474-2387 or Student Health Services at 850-474-2172.		

List ANY medication (s) you are currently taking.	
List any allergies you may have to medications:	
List any other allergies you may have :	
Comments:	



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Name: _____

Review of Systems:

Height _____ Weight _____ Temp _____ Pulse _____ Resp _____ BP ____/____

Systems Examination: Indicate if system is With in Normal Limits (WNL) or Explain Exceptions

SYSTEM	WNL	EXCEPTIONS/ISSUES/PRACTITIONER CONCERNS
Neurological		
Sensory		
Musculoskeletal		
Respiratory		
Cardiovascular		
Gastrointestinal		
Reproductive		
Integumentary		
Cognition		

General State of Health: Excellent ____ Good ____ Fair: ____ Poor: ____

Practitioner is to indicate summary of findings by checking responding to the statement below:

This student **IS** cleared to work in a high stress clinical/medical setting.

This student **IS NOT** cleared to work in a high stress clinical/medical setting.

Practitioner's Signature: _____ Date: _____

Name (Printed): _____

License number: _____ State Licensed: _____

Licensed as (check one):

Physician

Physician's Assistant

ARNP

This completed form is to be uploaded to your Magnus account.