

Student Statement of Health

(To be completed by student and uploaded to Viewpoint Screening by the stated deadline. This form must be submitted annually while continuously enrolled in the nursing program).

Academic Year: _____ Empl ID: _____

Name: _____

Mailing Address: _____

Cell Phone: _____ Home Phone: _____

VCCS Student Email: _____

Indicate if you have ever been diagnosed or treated or are currently under care for any of the following. Please indicate with a Y (yes) or N (no). Provide additional information as indicated on back of form.			
Condition	Explanation	Condition	Explanation
Asthma or any other respiratory problems		Kidney Problems	
Bladder		Low blood sugar	
Blood disorders: (hemophilia, sickle cell anemia, etc.)		Musculoskeletal Problems	
Cardiac		Pregnant	
Diabetes		Neurological problems (gait, smell, touch)	
Fainting/Dizziness		Seizures	If yes, date of last seizure:
Hearing Problems		Vision problems (wear Glasses or contacts)	
High Blood Pressure		Other medical or psychiatric problems	
Are you under medical care for any of the conditions circled above? If yes, explain (provide additional information on back of form)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
List name and purpose of any medications you are taking, including OTC.			
Do you have any health problems that may interfere with your ability to function as described in the student handbook (https://www.vhcc.edu/nursing-student-orientation) If yes, (Provide additional information on back of form)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your general health <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
List drug, food or other allergies (i.e. latex allergy) and any medical attention that may be required in an emergency situation.			
Date of Initial PPD:			
Name and Phone Number of Physician or Nurse Practitioner:			

EBOLA SCREENING		
<p>Have you traveled to an Ebola virus affected area (Guinea, Liberia, Sierra Leone, Mali) in the 30 days prior to beginning a clinical rotation.</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>I agree to notify the nursing faculty and the clinical agency if I have been in contact with an individual who is sick and has traveled to an Ebola virus affected area in the 30 days prior to a clinical activity.</p> <p style="text-align: center;">Initial _____</p>		
EMERGENCY CONTACT INFORMATION:		
<p>In case of emergency, I give Virginia Highlands Community College Nursing permission to obtain medical assistance and to notify my emergency contact person(s).</p> <p>Signature of Student: _____ Date _____</p>		
Emergency Contact Name:	Address:	Phone Number(s):

BY MY SIGNATURE BELOW, I VERIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS A TRUE AND ACCURATE REPORT OF MY HEALTH STATUS AND I AUTHORIZE VIRGINIA HIGHLANDS COMMUNITY COLLEGE NURSING TO RELEASE THIS INFORMATION TO THE AGENCIES WHERE I HAVE CLINICAL LABORATORIES.

Student Signature: _____ Print Name: _____ Date: _____