Virginia Appalachian Tricollege Nursing Program
Student Statement of Health

To be filled out completely by student and returned to the VATNP office, PO Box 828, Abingdon, VA 24212, by August 1 for day and evening weekend students, by May 15 for LPN-RN or Parmedic-RN bridge students, by beginning of semester for readmitted students. Must be completed and submitted annually while continuously enrolled in VATNP nursing program.

NAME: ____________________________________ ACADEMIC YEAR ______________

EMPL #: ___________________________ HOME PHONE: _________________CELL PHONE: _____________________

MAILING ADDRESS: ____

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 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/contacts	
High Blood Pressure		Other medical or psychiatric problems	

1. Are you under medical care for any of the conditions circled above? Yes No
   If yes, explain (provide additional information on back of form)
2. List name and purpose of any medications you are taking, including OTC. (Provide additional information on back of form)
3. Have you had any significant health changes in the last 12 months? Yes No
   If yes, explain (provide additional information on back of form)
4. Do you have any health problems that may interfere with your ability to function as described in the VATNP student handbook (www.vhcc.edu/vatnp) ? Yes No (If yes, provide additional information on back of form)

Describe your general health (circle): Excellent Good Fair Poor

List drug, food, or other allergies and any medical attention that is may be required in an emergency situation:
Latex allergy? Y N

Date of Annual PPD:

Name & phone number of physician or nurse practitioner:

EMERGENCY CONTACT INFORMATION:

In case of emergency, I give the Virginia Appalachian Tricollege Nursing Program permission to obtain medical assistance and to notify my emergency contact person(s).

Signature of Student_________________________________ Date ______________________

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 THAT I AUTHORIZE THE VIRGINIA APPALACHIAN TRICOLLEGE NURSING PROGRAM TO RELEASE THIS INFORMATION TO THE AGENCIES WHERE I HAVE CLINICAL LABORATORIES.

SIGNATURE: _________________________ Print Name: _________________________ **DATE:** _____________