BLESSING-RIEMAN
College of Nursing & Health Sciences

Student Name: ____________________ Date Of Birth: _____________

Permanent Address: __________________ Class: SO JR SR RN LPN AP

City, State, Zip: _________________________ Local Phone: _______________

To be completed by all students! At Blessing-Rieman College of Nursing, we request the following information to ensure that your health will not interfere with your ability to perform as a nurse . ***We ask you to complete the following assessment and return it to Scott Geschwandner at the Student Service table during your registration/orientation***.

Scott Geschwandner, Student & Alumni Services Officer
Blessing-Rieman College of Nursing & Health Sciences

To be completed by Student: Have you had, or do you now have, the following? Please answer "yes" or "no" by placing a check mark in the appropriate box.

Indications	Yes	No	Indicators	Yes	No
Tuberculosis			Back Conditions:		
Hepatitis			Pain		
Heart Disease			Sciatica		
Headache, Fainting, Dizziness			Other		
Convulsions, Epilepsy, Seizure			Allergies:		
Diabetes			Food		
Rheumatic Fever			Medications		
Three day Measles			Latex		
Rubella (German Measles)			Other		
Rubeola (Reg. Measles)			Mumps		
Chickenpox			Pretussis (Whooping Cough)		

Continued ….

1. Please list any and all allergies that you have.

2. Do you have any conditions, illnesses, or diseases that may interfere with your ability to fulfill clinical experience activities?

3. Are you taking any medications that may interfere with your ability to fulfill clinical experience activities?

If your answer to any of the above Questions is “yes” please give an explanation:

Signature:____Date:____________

Student/CAMs ID #______________________________