

SCHOOL OF NURSING  
HAMPTON UNIVERSITY  
HAMPTON, VIRGINIA

HEALTH STATEMENT

Please complete and return to the School of Nursing, Hampton University, Hampton, Virginia, 23668 on or before the first day of the semester.

Name \_\_\_\_\_ Date of Annual Physical Exam \_\_\_\_\_

REQUIRED ANNUALLY

1. PPD or Chest X-Ray if PPD positive      Date \_\_\_\_\_      \*After initial Chest X-Ray repeat only if  
Results \_\_\_\_\_      symptoms present

SUBMIT ONLY ONCE (unless updating information)

- 1. Diphtheria Tetanus TD Booster \_\_\_\_\_  
(in last 10 years)
  
- 2. Hepatitis B Virus      Date \_\_\_\_\_      Immune Status \_\_\_\_\_  
x 3 immunizations      1. \_\_\_\_\_  
or documented titer      2. \_\_\_\_\_  
evidencing immunity      3. \_\_\_\_\_
  
- 3. MMR      Date \_\_\_\_\_      Immune Status \_\_\_\_\_  
Immune titer or      1. \_\_\_\_\_  
x 2 immunizations      2. \_\_\_\_\_
  
- 4. Polio      Date \_\_\_\_\_      Immune Status \_\_\_\_\_  
Series Completed
  
- 5. Varicella      Date \_\_\_\_\_      Immune Status \_\_\_\_\_  
Immune titer      1. \_\_\_\_\_  
or      2. \_\_\_\_\_  
x 2 immunizations

Please list any medications and/or prescription drugs required on a regular basis and any chronic health problems:

The above named person has been given a complete physical examination and is found to be free of infection and contagious disease at this examination.

Signature of Physician/Nurse Practitioner \_\_\_\_\_ Address \_\_\_\_\_  
Telephone # \_\_\_\_\_