

**ARMSTRONG ATLANTIC STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
Health Report For Faculty And Students
Annual Physical Exam**

Name	Student ID #
Address	
<i>Date of Physical Exam</i> _____	<i>Name of Examiner</i> _____ <i>Please print or type</i>
I have examined _____ and find:	
1. <input type="checkbox"/> no evident health problems which could interfere with the performance of required clinical activities.	
2. * <input type="checkbox"/> the following health problem(s)/restriction(s) which may/may not interfere with his/her performance of required clinical activities	
3. * <input type="checkbox"/> significant health problem(s) which would interfere with his/her performance of required clinical activities.	
BP _____ Pulse _____ Resp _____ Temp _____	
Ht. _____ Wt. _____ Hgb _____ U/A _____	
PPD Date _____ Results/Size _____ (Must be completed annually)	
<i>If PPD is positive, statement from physician or healthcare provider stating the recommended time for a follow-up will be needed (Attach Physician's Evaluation)</i>	
Date of Radiograph _____	
Was there Prophylaxis? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>If yes, what prophylaxis has been prescribed?</i>	
Signature of Health Care Provider	Street Address/City/State/Zip Code

(*Please explain #2 or #3 if checked and attach additional pages if necessary.)

RETURN TO: **Department of Nursing**
Armstrong Atlantic State University
11935 Abercorn Street
Savannah, GA 31419-1997



**UNIVERSITY SYSTEM OF GEORGIA
REQUIRED
CERTIFICATE OF IMMUNIZATION**
(Return to: Nursing Department)

Return documentation to the college or university that you are applying to. Retain a copy of the completed form for your records.

STUDENT INFORMATION

Student ID: _____

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Term/Year of Application: _____ Age at time of application: _____ Date of Birth: _____

REQUIRED IMMUNIZATION INFORMATION (See the Immunization Requirements & Recommendations for USG Students documentation)

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMRI	/ /	/ /			
Measles ₁	/ /	/ /			/ /
Mumps ₁	/ /	/ /			/ /
Rubella ₁	/ /	/ /			/ /
Varicella ₃	/ /	/ /		History of Varicella / /	/ /
Tetanus-Diphtheria (DTP, DTaP, Tdap, or Td within 10 years)	most recent / /				
Hepatitis B ₂	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 3 Dose Series	/ /

1—Not required if born before 1957

2—Only required of students who are 18 years of age or younger at time of expected matriculation.

3—Required for all US born students born in 1980 or later; all foreign born students regardless of year born.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

- This student is exempt from the above immunizations on the ground of permanent medical contraindication.
- This student is temporarily exempt from the above immunization until ____/____/_____.

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name: _____ Signature: _____

Address: _____

Date of Issue: ____/____/____ Telephone: _____

EXEMPTIONS

Check the appropriate box, sign, and date if you are claiming exemption of the immunization requirement for one of the following reasons:

- I affirm that Immunization as required by the University System of Georgia is in conflict with my religious beliefs.
I understand that I am subject to exclusion in the event of an outbreak of a disease for which immunization is required.

Student Signature: _____ Date: ____/____/____

- I declare that I will be enrolling in ONLY courses offered by distance learning.
I understand that if I register for a course that is offered on-campus or at a campus managed facility this exemption becomes void and I will be excluded from class until I provide proof of immunization.

Student Signature: _____ Date: ____/____/____

**ARMSTRONG ATLANTIC STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
HEPATITIS B DECLARATION FORM**

Faculty and Students

DEPARTMENT: _____

Name: _____
Major: _____

I understand that Hepatitis B is a severe and potentially life threatening illness. Hepatitis B vaccination significantly decreases my risk of being infected by the Hepatitis B virus. Therefore, I agree to take the prescribed series of inoculations and follow-up titre to assess antibody level, and a second series if necessary. I assume responsibility for all arrangements, costs and complications arising from this vaccination procedure.

Signature: _____
Date: _____

I understand that Hepatitis B is a severe and potentially life threatening illness. Hepatitis B vaccination significantly decreases my risk of being infected by the Hepatitis B virus. I understand also that not taking the vaccination may significantly increase my risk of being infected by the Hepatitis B virus. Nevertheless, I elect not to take the prescribed vaccination procedure, and assume responsibility for all arrangements, costs and complications arising from not taking this vaccination procedure.

Signature: _____
Date: _____

I have already received the vaccine.

Signature: _____
Date: _____

