



**Medical History of Applicant (To be completed by student)**

**Explain positive responses below.**

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
Previous Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Mental or Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Operations	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath/Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Current Medication/Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Cardio Vascular	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Other Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Illnesses	<input type="checkbox"/>	<input type="checkbox"/>	Other Significant Medical History	<input type="checkbox"/>	<input type="checkbox"/>

---

---

**Medications**—Please list all medications taken on a regular basis with dosage:

---

---

**Allergies**—Please list all known medical allergies:

---

**STATEMENT AND CONSENT**

I hereby give permission to release to the Texas A&M Health Science Center College of Nursing, this and any additional information regarding my health status. I understand this to be used for enrollment and teaching purposes only.

---

Student Signature

---

Date

---

Printed Student Name

I certify that the information given on this form is true and correct, and I have no abnormality, limitation, or restriction not mentioned on this document. I understand that any false information, willful or negligent misrepresentation, or failure to disclose any request d information will constitute sufficient grounds for dismissal from the Texas A&M Health Science Center College of Nursing. I agree to notify the College of Nursing of any change in my physical or mental health either prior to my registration or while I am a student. I acknowledge by my signature that I have read and understand these statements.

---

Student Signature

---

Date

---

Printed Student Name

**ANY INCORRECT INFORMATION ON THIS FORM MAKES STUDENT SUBJECT TO DISMISSAL FROM THE TEXAS A&M HEALTH SCIENCE CENTER COLLEGE OF NURSING PROGRAM.**