

History of major illness, injury, or of surgery: _____

Current health status, including disabilities: _____

Current medications: _____

Allergies: _____

Evidence of Physical Examination within the past year:

By Whom? _____ Date: _____

Address:

Any problems noted? _____

Hematocrit: _____ Blood Pressure: _____

Urinalysis: _____ Pap Test: _____

G.C. Culture (date done-results not reported to GSU): _____

PLEASE RETURN TO:
Office of Records and Information
Graduate Programs, Byrdine F. Lewis School of Nursing
Georgia State University
902 Urban Life Center
P.O. Box 4019
Atlanta, GA 30302-4019

**GEORGIA STATE UNIVERSITY
Byrdine F. Lewis School of Nursing
Graduate Programs**

**DATA SHEET
(To be completed by student)**

1. Name: _____

2. Address: _____

3. Employer: _____

4. Whom to notify in case of an emergency:

Name: _____

Address: _____

Telephone: _____

Relationship: _____

Please attach a recent photo.

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