Department of Nursing

Nursing Program Physical Exam Form

TO BE FILLED OUT BY STUDENT:

Name: ____ Sex: M / F Age: _____ Date of Birth: ____/____/____

Cell Phone: __________________ Email: ________________________________ Student ID#: _____________

Home Address: ____
Street *City* *State* *Zip*

Person to notify in case of emergency: ____________________________________ Relationship: _____________

Address: ____
Street *City* *State* *Zip*

Phone: _________________________ Alternate phone: ___________________________

Family History:

	Age	Chronic illnesses	If deceased, cause of death
Father	________	__________________________________	_____________________________
Mother	________	__________________________________	_____________________________
Brother(s)	________	__________________________________	_____________________________
Sister(s)	________	__________________________________	_____________________________

Personal History:

Allergies (include medication, environmental, food allergies, and type of reaction: ___________________________
____

History of injuries, surgeries, hospitalizations: ____

History of previous illnesses (give year and status):

Anemia ______________________ Cardiac Condition___________________ Epilepsy ______________________

Anxiety/depression _____________ Diabetes _____________________ Kidney disease ______________________

Asthma _________________ Eating disorders ___________________ Seasonal Allergies____________________

Have you had any other severe illnesses not mentioned above? If so, give details: __________________________
____

Emotional problems? (Specific details): ____
____

List medications taken at present (include dose and frequency): ____
____

Comments: ____
____

Student Signature: ____ **Date:** ____________________

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TO BE FILLED OUT BY HEALTHCARE PROVIDER:

Student Name: ____ Date of Birth: _____/_____/_______
(last, first, middle initial)

Height: __________ Weight: ____________ Pulse: ______________ Blood Pressure: ________________

Please indicate if abnormal findings are present in areas listed below, and comment briefly:

	Yes	*No*	*Comments*
Skin	_____	_____	____
Head, EENT	_____	_____	____
Neck, nodes	_____	_____	____
Cardiovascular	_____	_____	____
Respiratory	_____	_____	____
Gastrointestinal	_____	_____	____
Musculoskeletal	_____	_____	____
Endocrine	_____	_____	____
Neurological	_____	_____	____
Psychiatric	_____	_____	____

Do you have any recommendations regarding the care of this student? Yes_____ No_____

Comments: ____

Is the student now under treatment for any medical conditions? Yes_____ No_____

Comments: ____

Does this student have any clinical physical activity limitations, hearing loss or vision loss? Yes_____ No_____

Comments: ____

<u>The following are performance standards that students must meet.</u>

The student must be able to:

1. Assess, plan, implement care, and teach patients in various clinical settings they may be assigned, including home health, public health clinical sites, hospitals, and school settings.
2. Provide nursing care to individuals, families and communities.
3. Provide nursing care to patients including, but not limited to, in homeless shelters, day care centers for patients with mental health issues, frail elderly population, schools, and maternal-child health clinics.

The student is cleared to perform nursing activities in clinical with the following restrictions:

_______**No restrictions**

_______**Restrictions:** ____
____
____
____

Healthcare Provider's Signature: ____**Date:** ______________

Healthcare Provider Stamp (required)**:**