



Nursing Program Physical Exam Form

**TO BE FILLED OUT BY STUDENT:**

Name: \_\_\_\_\_ Sex: M / F Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle Initial

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:** \_\_\_\_\_

## Vanguard University Nursing Physical Form

Student Name (last, first, middle initial)

Date of birth

### Physical Examination

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	_____	_____	_____

Health care provider's signature: \_\_\_\_\_ Date: \_\_\_\_\_

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: \_\_\_\_\_

Does the Application have any lifting restrictions? \_\_\_\_\_

**The following are performance standards that students must meet in clinical.**

**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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Health care provider's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_