Student Name: _____ Birth Date: _____

Exam Date: _____

Student Health History and Physical Evaluation Form

This form includes three parts. Please complete Part 1 and take it with you to your appointment with your health care provider. Your provider will complete Parts 2 and 3.

PART 1: HEALTH HISTORY – to be completed by the student and presented to the health care provider.

List any prescription or non-prescription medications you are taking: _____

_____

_____

List any allergies: _____

Are you pregnant? _____ Due date: _____

Have you had chicken pox? Yes No When: _____

Please check if you or a family member has a history of any of the following conditions:

Condition	Self	Family	Explanation
Arthritis			
Back Problems			
Cancer			
Diabetes			
Hearing Impairment			
Heart Problems			
Hepatitis			
High Blood Pressure			
Kidney Problems			
Lung Problems			
Orthopedic Problems			
Seizures			
Speech Problems			
Surgeries			
Tuberculosis			

Emergency Contact Information

Name: _____ Relationship to Student: _____

Phone #: _____ Address: _____

The information provided is true and correct to the best of my knowledge and I am aware that this information will be released to clinical affiliations upon request.

Student Signature: _____ Date: _____

I verify that I have reviewed this information with student.

_____ _____

Signature of Physician/ Nurse Practitioner ***Print Name of Physician/ Nurse Practitioner***

Student Name: _____ Birth Date: _____

Exam Date: _____

PART 2: PHYSICAL EVALUATION (to be completed by a health care provider)

Height: _____ Weight: _____

Temp: _____ Pulse: _____ Resp: _____ BP: _____

WNL		Document Abnormalities
	Neurologic	
	Respiratory	
	Gastrointestinal	
	Urinalysis Dip, as indicated	
	Musculoskeletal	
	Cardiovascular	
	Mouth	
	Neck	
	Chest	
	Skin	
	Hernia	
	Back	
	Thyroid	
	Extremities	
	Allergies	
	Vision	
	Hearing	

Prescription Medications (Dosage, regime, reason): _____

_____

_____

_____

_____

Does your examination of the student reveal any evidence of communicable disease?

☐ Yes ☐ No If yes, please explain_____

Other comments:_____

_____

_____

To the healthcare provider; please provide student with copies of laboratory results and any immunization records.

This information is subject to release to hospitals and community agencies where students are placed.

Please continue to page 3

Student Name: _____ Birth Date: _____

Exam Date: _____

Essential Functional Abilities of the Nursing Student

Medical Clearance Form

***All students must have a complete physical examination and have their healthcare provider complete and sign this form annually and following any changes in health status*.**

ISSUE	EXAMPLES OF NECESSARY ACTIVITIES (NOT ALL-INCLUSIVE)	STANDARD
Mobility	Move around in small spaces, perform CPR, lift 50 pounds and exert up to 100 pounds force to push/pull. Squat, stoop/bend, reach above shoulder level, use standing balance, walk stairs. Able to walk and stand for extended periods of time.	Physical abilities sufficient for movement from room-to-room in small spaces.
Motor Skills	Position patients, use hands repetitively, use manual dexterity, travel to/from academic sites.	Gross and fine motor abilities sufficient for providing safe, effective care.
Hearing	Hear monitor alarm, emergency signals, auscultatory sounds, and cries for help.	Auditory ability sufficient for monitoring and assessing health needs.
Visual	Observe patient/client responses.	Visual ability sufficient for observation and assessment and documentation necessary in nursing care.
Communication	Interact, initiate health teaching. Document and interpret nursing actions and patient responses.	Communication abilities sufficient for verbal, nonverbal, and written interaction with patients, families, and other healthcare providers.
Critical Thinking	Identify cause/effect relationships in clinical situations, function effectively under stress.	Critical-thinking ability sufficient for clinical judgment.

*Adapted from the Council on Collegiate Education for Nursing

I certify that the above named student has been examined by me on ____/_____/_____. She/He is found to be in good physical and mental health as outlined above. I have determined that this student may participate in laboratory, lecture AND clinical experiences with NO restrictions.

_____ _____

Healthcare Provider Signature ***Effective Date***

Printed Name and Title: _____

Phone: _____ *Address:* _____

City: _____ *State:* _____ *ZIP:* _____