BUNTAIN COLLEGE OF NURSING—MEDICAL CLEARANCE

Physical Exam/Medical History

SECTION 1: HEALTH CARE PROVIDER (HCP) SECTION

HCP:	Phone:	Date:
Address:	City, State:	Zip:

Note to HCP: Applicants to the Nursing Major are expected to have good physical health. It is most helpful to have knowledge of the health status of this student in planning his/her program. Your confidential report will be appreciated. Thank you.

PATIENT INFORMATION

Last:		First:	MI:	DOB:
Height:	Weight:	Blood Pressure:	HR:	Respirations:

PHYSICAL ASSESSMENT

SYSTEM	NORMAL	ABNORMAL	Not Done	ABNORMALITIES & FINDINGS
General Appearance				
Skin				
Head				
Eyes				Corrected Vision: (L) (R)
Ears, Nose				Hearing: (L) (R)
Neck, Throat, Mouth				
Breasts				
Thorax, Lungs				
Cardiovascular				
Abdomen				
Genito-Urinary				
Musculoskeletal				
Neurological				

Describe any condition (illness, injury, or emotional disturbance) which might affect the student's performance in the nursing program, and indicate current/recommended treatment: (attach additional sheets if necessary)

_____

_____

_____

_____

By signing below, I have determined that the named individual is eligible for clinical practice and agree with the following statements: I find him/her to be in good physical and mental health; he/she is free from any health impairment which is of potential risk to patients, personnel, students, or faculty and which might interfere with the performance of his/her nursing responsibilities (the student nurse role requires walking, bending, lifting, and standing for extended periods of time to manage, coordinate, and administer nursing care including the ability to lift 50 pounds and push/pull 200 pounds).

Signature of HCP:	Date:

SECTION 2: APPLICANT SECTION

PERSONAL HEALTH HISTORY/CURRENT CONDITIONS

Please place a checkmark in the appropriate box if you have had any of the following diseases, symptoms, or conditions.

☐ Abdominal Disorders	☐ Back Injury	☐ Fainting	☐ Hematologic Disorders	☐ Mental Health Disorders	☐ Vision Problems
☐ Anemia	☐ Chest Pain	☐ Headaches	☐ Hepatitis	☐ Neurological Disorders	
☐ Asthma	☐ Diabetes	☐ Hearing Problems	☐ High Blood Pressure	☐ Seizure Disorders	
☐ Autoimmune Disorders	☐ Dizziness	☐ Heart Disease	☐ Low Blood Pressure	☐ Skin Conditions	
☐ Other conditions affecting mobility or strength/ability to lift?					

Comment below on any conditions or diseases for which you indicated yes. Include when occurred/diagnosed, current symptoms, plan for treatment. (Add additional pages if necessary.)

List any other operations, diseases, conditions, or symptoms that you consider important for the nursing faculty to know with regards to your ability/health as a student nurse. (Add additional pages if necessary.)

MEDICATION TAKEN REGULARLY (prescription and non-prescription)

MEDICATION	MEDICATION

ALLERGIES TO MEDICATIONS, SUBSTANCES, AND FOOD

ALLERGY	REACTION/TREATMENT

***Health Care Costs**: Clinical sites will not provide treatment for illness or injury free of charge. The student is responsible for the cost of her/his health care needs. Clinical sites require all nursing students to have their own health and accident insurance.*

Name of Health Insurance Carrier_____ Group No_____

EMERGENCY CONTACT INFORMATION

Name:	Email Address:	Home Phone:
Address:		Cell Phone:

SIGNED STUDENT DISCLOSURE

I certify that the information provided is true and complete to the best of my knowledge. I authorize the release of this information to the Buntain College of Nursing at Northwest University.

Full Name (print)_____

Signature_____ **Date**_____