Physical Examination Form

Name: _____ HPU ID Number: _____

Immunization Record and Health Report to be signed or stamped by health care provider.
Information written on this report is NOT proof of immunization or labs.

IMMUNIZATIONS & SCREENS	
Mumps Screen	Positive screen/titer is required - attach copy of lab result. If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received.
Rubeola Screen	Positive screen/titer is required - attach copy of lab result. If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received.
Rubella Screen	Positive screen/titer is required - attach copy of lab result. If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received.
Varicella Screen *(Vz)*	Positive screen/titer is required - attach copy of lab result. If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received.
Hepatitis B Screen *(HbsAb)*	Positive screen/titer is required - attach copy of lab result. If a screen/titer is equivocal or negative you are required to receive the appropriate immunization. The screen/titer should then be redrawn a month after the appropriate immunization has been received..
Tdap *(Tetanus/Diphtheria/Acellular Pertussis)*	Immunization within the last 10 years is required For adults: Those who did not get the Tdap should get one dose as a booster. Most pregnant women not previously vaccinated with Tdap should get a dose before leavingthe hospital. (Source: U.S. Centers for Disease Control and Prevention)
Tuberculosis *(TB/Mantoux/PPD)*	Two annual TB tests OR One 2-step TB test is required: - 2-step TB tests: two TB tests within a two-week time period, the second one administered a week after the first one is read. Must be less than a year old. - 2 annual TB tests: tests must be less than 365 days apart *and* must be less than a year old. - Positive TB test: original positive TB test results including date and inundation is required, along with an x-ray report/card with clear or negative findings. X-ray must dated no earlier than your start year in the nursing program.

Student Signature: _____ **Date:** _____
Student's Signature is acknowledgement that they understand the requirements of immunizations.

Health Care Provider Signature: _____ **Date:** _____

HEALTH QUESTIONNAIRE

To be completed by Student prior to Physical Examination

_____ Yes	_____ No	No Do you have any physical limitations that would affect your ability to lift, turn, or transfer patients?
_____ Yes	_____ No	No Do you have any limitations in use of your senses, such as in sight, hearing, which would limit your ability to practice a health profession?
_____ Yes	_____ No	No Do you have any other condition that might interfere with your ability to practice in the health care profession?

If you answered "yes" to any of the above, explain your limitations in detail. Include any medications you take on a regular basis (in the past year). Attach a separate sheet of paper if necessary.

_____

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History: Include any significant information regarding previous medical/surgical or psychiatric conditions and use of alcohol or drugs:

_____

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Student Signature: _____ **Date:**_____

PHYSICAL EXAMINATION FORM

Health Care Provider's Certification of Fitness

Students will be examined for evidence of being able to meet the physical requirements necessary for a nursing student:

- Ability to stand, sit, kneel, bend, push, pull, carry, walk, reach, and twist
- Manual dexterity to perform fine motor tasks needed for essential nursing tasks and use of equipment.
- Ability to see, hear, and feel.
- Ability to lift at least 50 pounds (essential to assist clients with ambulation, transfers, positon changes, transport).

Any comments r/t history provided: _____

_____

Gender: _____ Age: _____ Height: _____ Weight: _____

Blood Pressure: _____ Pulse: _____

Build: ☐ Slender ☐ Medium ☐ Heavy ☐ Obese

Color Vision: _____ Vision: OD 20/_____ OS 20/_____ Corr-to 20/_____

Lab Data (if indicated): HGH: _____ WBC: _____ Urinalysis (dipstick): _____

NORMAL	PHYSICAL ATTRIBUTE	ABNORMAL	DETAILS OF ABNORMALITY
	Head, neck, face & scalp		
	Eays, ears, nose		
	Mouth, teeth, gingiva & throat		
	Thyroid		
	Lungs		
	Heart & vascular		
	Abdomen & viscera		
	Hernia		
	Neck, back & spine		
	Upper extremeties		
	Lowere extremeties		
	Other musculoskeletal		
	Skin & lymphatics		
	Neurologic		
	Pshychiatric *(specify deviations noted)*		

I have examined _____ and have found her/him to be free from any impairments or restrictions that may impede functioning in a health care role.

Comments: _____

Signature of Health Care Provider and License Number _____

Printed name of Stamp of Health Care Provider _____

Date _____ Address _____