Student ID: _____

ASSOCIATE DEGRENURSING PROGRAM
STUDENT HEALTH FORM

Start Date: ____ Fall ____ Spring Year: _____

Directions: Please print in ink or type Section I before going to your medical provider for examination. Be sure to answer ALL questions. Information provided will not influence your admission status and will not be released to unauthorized persons without your written consent.

SECTION I (To be completed by student)

Date: _____

Name: _____
(Last) (First) (Middle or Maiden)

Home Address: _____
(Street) (City) (State and Zip Code)

Student ID #: _____ Birthday: _____

Home or Cell Phone: (___) ___ - ____ Work Phone (leave blank if N/A): (___) ___ - ____

IN CASE OF EMERGENCY, NOTIFY:

Name: _____ Relationship: _____

Address: _____
(Street) (City) (State and Zip Code)

Telephone: _____ _____
(Home) (Cell or Work)

Student ID: _____

ASSOCIATE DEGRENURSING PROGRAM
STUDENT HEALTH FORM

A: PAST MEDICAL HISTORY

INSTRUCTIONS: Complete the following, then have it reviewed and signed by your Primary Care Provider (Licensed Physician, Physician's Assistant, APRN, etc.). Failure to have this signed will result in the form being rejected.

Check **all** boxes below. Indicate current or past diagnosis on **all** "Yes" answers:

Have you had	Yes	No	Have you had	Yes	No
Allergies/Hay fever			Immunosuppression		
Anemia			Kidney Disease		
Anxiety/Nervousness			Loss of Extremity		
Arthritis			Lung Disease		
Asthma			Measles (Rubeola)		
Back problems			Migraines		
Blood disorder			Mumps		
Bronchitis			Pacemaker		
Cancer			Peripheral Vascular Disease		
Chicken Pox			Prostate Disease		
Complicated Pregnancy			Prosthesis		
Depression			Rubella		
Diabetes			Scarlet Fever		
Dizziness/Fainting/Syncope			Shingles/whitlow		
Emphysema			Skin Lesions		
Epilepsy/Seizures			STD		
Frequent Infections			Stroke		
Gallbladder Disease			Substance Abuse		
GERD			Surgeries		
Glaucoma			Thyroid Disease		
GOUT			Tobacco Use		
Hearing Loss			Tuberculosis		
Heart Condition			Tumors/Growths		
Heart Murmur			Ulcer		
Heart Palpitations			Valve Prolapse		
Hepatitis			Varicose Veins		
Hernia			Vision Loss		
HIV			Other		
Hypertension					

If you answered "Yes" to any question above, indicate below whether current or past diagnosis:

Problem	Current	Past

I have reviewed the information indicated above.

_____ _____

Provider Signature Date

B. PHYSICAL REQUIREMENTS FOR NURSING STUDENTS

1. The Nursing profession requires the ability to perform the following physical activities for prolonged lengths of time: walking, standing and sitting for long periods; stooping; lifting patients; squatting; reaching; twisting, bending and pushing/pulling/dragging; climbing; manual dexterity skills. A letter from your medical provider will be required in order to attend skills lab and clinical if you are unable to perform these tasks. Please include the letter with this health form when you submit your forms to CastleBranch.

2. Has your physical activity been restricted or limited during the past three years? This includes your ability to perform the following occupational activities: walking, standing and sitting for long periods; stooping; lifting patients; squatting; reaching; twisting, bending and pushing/pulling/dragging; climbing; manual dexterity skills. A letter from your medical provider will be required in order to attend skills lab and clinical if you are unable to perform these tasks. Please include the letter with this health form when you submit your forms to CastleBranch.

   ☐ Yes ☐ No

NOTE: Student is responsible for the completion of the following Physical Examination Form. This includes signatures from your provider and all attachments. Failure to ensure the form is complete will result in rejection of the form when uploaded to CastleBranch.
Physician/Physician's Assistant/Nurse Practitioner fills in all spaces on physical exam section.

Physical exam must be within six (6) months prior to the first day of class.

See the ADN Information Packet for further information regarding physical requirements for the Nursing Program.

If you have questions regarding your health information, please contact Dr. Trilla Mays by email: mayst@chipola.edu

SECTION II: MEDICATIONS

Student Name: _____

Date: _____

Please keep this list updated at all times:

Name of Medication	Dosage (amount in number or mg's)	Frequency (times taken)

SECTION III: PHYSICAL EXAMINATION (To be completed by Provider)

Directions to the Medical Provider:
Please review the student's Past Medical History (see page 4), complete the Physical Examination below, check all systems "Normal" or "Abnormal", and comment on all abnormal findings. The information you provide will not influence the student's admission status to the Nursing program.

Student Name: _____
(Last) (First) (Middle)

Corrected Visual Acuity

Right: 20/_____ Left: 20/_____

Hearing Screen

Right: ☐ Normal ☐ Impaired*

Left: ☐ Normal ☐ Impaired*

**If hearing screen is found to be impaired, a hearing evaluation with audiometric equipment is required.*

Allergies:

Drug Allergies: _____

Food Allergies: _____

Other Allergies: _____

Student ID: _____

ASSOCIATE DEGRENURSING PROGRAM
STUDENT HEALTH FORM

Student Name: _____
(Last) (First) (Middle)

Height: _____ Weight: _____ Blood Pressure: _____

A: SYSTEMS *Please check "normal" or abnormal" (Provide dates, description for abnormality and treatment on all positive findings under section B.)*

SYSTEMS	Normal	Abnormal
Eyes		
Ears		
Nose, Throat		
Neurological		
Respiratory		
Cardiovascular (to include heart murmurs)		
Gastrointestinal		
Musculoskeletal		
Metabolic/Endocrine		
Genitourinary		
Skin		
Immunological		
Psychiatric		

B: DIAGNOSIS (Based on abnormalities identified in section A)

Date	Diagnosis	Treatment

Does the patient have an active disease or is any treatment being followed which should be periodically checked? If so, explain:

_____

_____

_____

Is the patient receiving chronic therapy for any of the above conditions? (ex: Physical Therapy, Hemodialysis, Chemotherapy, etc.) ☐ Yes ☐ No

Does the patient have any specific physical or emotional factors that would preclude/limit them from participating in classroom and/or clinical education?

_____

_____

_____

_____

In my opinion, this applicant is free from communicable disease and will not compromise the immunosuppressed patient with whom they will come in contact. The applicant's physical and mental health is compatible with that required for this program.

_____ _____

Signature of Healthcare Provider Date

Provider's Name (Print): _____

Office Address and Phone: _____

_____