



Student Health History and Physical Evaluation Form

Student Name: _____

Exam Date: _____

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 (Asthma, other)			
Orthopedic Problems			
Seizures			
Speech Problems			
Surgeries			
Thyroid Problems			
Tuberculosis			
Vision Problems (glasses, contacts, other)			

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: _____



Student Health History and Physical Evaluation Form

PART 2: PHYSICAL EVALUATION - To be completed by a health care provider

Height: _____ Weight: _____ Pulse: _____ Resp: _____ BP: _____ Temp: _____

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: _____

Students may be required to wear respiratory protection (half-face N95) for up to 12 hours during a clinical shift in a hospital or ambulatory setting. Fit testing will be conducted according to agency policies. Please select one of the options below:

Student is physically able to undergo fit testing and wear a respirator without restriction (pending results of fit-test).

Student is physically able to undergo fit testing and wear a respirator WITH RESTRICTIONS: (Please describe)

Student IS NOT physically able to undergo fit testing and wear a respirator. Comments:

To the healthcare provider: please provide the 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.

Provider: I verify that I have reviewed this information with the student.

Signature of Health Care Provider

Print Name of Health Care Provider



Student Health History and Physical Evaluation Form

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: _____