**NCWU Pre-Licensure Nursing—MEDICAL CLEARANCE**

## Physical Exam/Medical History

**SECTION 1: EXAMINER SECTION**

|  |  |  |
| --- | --- | --- |
| Examiner: | Phone: | Date: |
| Address: | City, State: | Zip: |

Note to Examiner: 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 Examiner: | 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 Pre-Licensure Nursing Program of North Carolina Wesleyan University.*

**Full Name** (print)

**Signature Date**