Ralph R Willis Career and Technical Center
School of Practical Nursing

MEDICAL HEALTH EXAMINATION RECORD

Section I
To be completed by the physician

Students Name: ____

A. Vital Signs: ____
B/P TPR Height Weight

B. Vision: ____
OD OS Comments

C. Hearing: ____
AD AS Comments

D. Check deviations from normal:

_____ Nose and Sinuses

_____ Throat and Neck

_____ Mouth and Teeth

_____ Skull and Scalp

_____ Lymphatic System

_____ Breasts

_____ Lungs/Chest

_____ Arteriosclerosis

_____ Heart

_____ Thyroid

_____ Upper Extremities

_____ Muscular Size and Strength

_____ Hernia

_____ Genitourinary

_____ Gynecological

_____ Anorectal

_____ Varicose Veins

_____ Feet

_____ Lower Extremities

_____ Neurological

_____ Psychiatric

_____ Skin

_____ Eyes

_____ Orthopedics (posture/spine)

E. In the space below, please provide details of the deviations from normal you noted in section D. ____
____

SECTION I (cont'd)

Health Requirements:

Student Name: ____

1. Immunizations-as required: **2-step PPD test**, Tetanus and Diphtheria vaccine, Hepatitis B series, and each student will be required to have an influenza injection.
2. Proof of MMR and Varicella immunizations (shot record or titer)
2. Pre-entrance dental examination and repairs by family dentist.
3. Pre-entrance physical examination by a healthcare provider with will include a drug screen.

Please review student's immunizations record. Please note if student needs titers for Varicella MMR, and if applicable Hep B titer.

F. I hereby certify that:
(Miss, Mrs., Mr.) ____

Social Security# ____

Has properly attended to the following health tests:

1. **D. T.:** (recommended booster every 10 years) Date: _____________

These are mandatory- will not be allowed to attend clinical without either date of Immunizations or titers.

2. **MMR**

If you did not have measles and were born *after* 1957, two doses of MMR vaccine are required- OR- lab results of titer indicating immunity.

1st _________________ (Date)
2nd _________________ (Date)

If born ***before*** 1957, one dose of MMR-OR- lab results of titer indicating immunity

Titer Results _________ (Date)

3. **Varicella (Chicken Pox injection or titer)**

Date and Results ____

4. **PPD (must be within last 3 months)**

1. Date Given: ____

Result Date:_________________________ Read By:____________________

2. Date Given: ____

Result Date:________________________ Read By:____________
***MUST BE A TWO STEP**

5. **Hepatitis B Vaccine Series (Anyone already having the hepatitis B vaccine series will need to have serum titer)**

1. ____________________
2. ____________________
3. ____________________

Titer ___________
Date and Results

Nurse or Doctor Signature: ___________________________ Date: __________________

Section I (cont'd)

Laboratory Test Results:

G.
Please provide date completed and attach a copy of all results.

CBC: ____

Urine drug screen test: ___________________

Chest x-ray: (if indicated) _________

PPD: ________

H. **Any medical diagnosis made**: ____________________________

I. Any working conditions this application is to avoid

____

____

____

____

J. **Extent to which applicant may engage in gainful employment:**

None _____ Part-Time _____ Full-Time ______

K. **Recommendations**:

Do you consider the applicant mentally and physically able to undertake the program in practical nursing?
Yes _____ No ______

L. **Date of Examination**: ____________________

____
Signature of Examining Physician Date

Physician's Address and Telephone Number

____
Street City State Zip Code

____
Area Code Telephone Number Extension