



Part I: To be completed by Student:

Indicate program of application:

- Associate Degree Nursing
- Dental Hygiene
- Nursing Assistant/Home Health Assistant
- Vocational Nursing

Applicant information:

Last Name		First Name		MI	Maiden	
Address			City		State	Zip
email			Birth date		Gender M F	
Phone (day)		Phone (eve)		Phone (cell)		

Person to notify in case of emergency:

Full Name		Relationship		
Address – Number & Street		City	State	Zip
Home Phone	Work Phone		Cell	

HEALTH HISTORY

Please rate your current health status: Excellent Good Fair Poor

Certain minimum physical abilities and characteristics are required in health sciences professions. See attached for specific requirements. Do you have any condition that would interfere with your ability to perform the minimum technical skills standards for the program to which you are applying?

Yes No If yes, explain:

Are you pregnant? Yes No Due date: _____

Allergies/sensitivities (i.e. medications, foods, Latex/Powder): Please List: _____

Do you have any lifting restrictions: Yes No If yes, explain: _____

The information provided is true and correct to the best of my knowledge. I am aware that any change in my physical or mental health, including pregnancy, during the program may require that I obtain medical clearance to continue in the program.

Student Signature: _____ Date: _____



HEALTH DATA FORM/PHYSICAL EXAM (continued)

Applicant Name:	Date:
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Part II: To be completed by health care provider.

Identify any health conditions in the following:			
Head, ears, nose, throat	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Gastrointestinal	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Eyes	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Genitourinary (by report)	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Respiratory	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Musculoskeletal	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Cardiovascular	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Neurological	<input type="checkbox"/> Yes or <input type="checkbox"/> No
Hernia	<input type="checkbox"/> Yes or <input type="checkbox"/> No	Skin	<input type="checkbox"/> Yes or <input type="checkbox"/> No

If health conditions are present, do they create a limitation in the ability to provide health care? Yes or No

See program specific technical standards (attached).

Explain:

Does your examination of the student reveal any limitations in the following:			
SPINE: <input type="checkbox"/> Yes or <input type="checkbox"/> No	LIFTING: <input type="checkbox"/> Yes or <input type="checkbox"/> No	BENDING: <input type="checkbox"/> Yes or <input type="checkbox"/> No	<input type="checkbox"/> NO LIMITATIONS OF ANY TYPE

Does your examination of the student reveal any active illness that would be a hazard to others? Yes or No

Explain:

Physician or Approved Licensed Health Professional Information:	
Based upon today's exam and the disclosed health history, this student does not have any health condition that would create a hazard to self or others, or limit their ability to provide health care.	
Agency or Clinic providing service	
Printed Name	Title
Signature	Date