

HEALTH EVALUATION FORM (Parts I & II)

Applicant: Complete Part I, Sign your name at the bottom of this page.
 Show health professional, Part I, Documented immunizations, and/or Tests you have had.

Part II is to be completed by a health professional (i.e., physician, nurse practitioner, etc.).

PART I

Printed Name _____
(Last) (First) (Full Middle Name)

Mailing Address _____
(Number & Street) (City) (State) (Zip Code)

Social Security # _____ Cell Ph.# _____ Home Ph.# _____

Date of Birth _____ (Sex) Male _____ Female _____

HEALTH PROFESSIONAL: Please review Health History

Applicant: Check if you ever had, or currently have, any of the following:

	Yes	No		Yes	No
Anxiety			Impaired hearing		
Depression			Impaired sense of smell		
Diabetes			Impaired sense of touch		
Seizures/Epilepsy			Impaired vision		
Fainting / Dizziness			Lifting restriction		
ADHD			Other physical limitation(s):		
Other:					
Comments:					

1) Do you have any medication, food, latex, or other allergies? ___No ___Yes If yes, please list allergies: _____

2) Ever had a positive TB skin test? No___ If Yes___ complete the following: Attach copy of the first positive reaction documentation and a copy of the last Negative Chest X-Ray report plus a self-report letter of no abnormal symptoms since last negative CXR-available from ADN program.

Health care provider immunizations are required: MMR x 2, Hep B x 3, Varicella x 2, **Tdap (must have history of one Tdap, then TD/Tdap boosters must not expire prior to your graduation date).**

TB skin test must not expire before May of your first year. Influenza vaccine **for traditional students** will be required when you are directed to do so in the Fall **but** if you are a Bridge applicant, it should be up to date for clinical in June.

Do you take any routine medications that may impair judgment, alertness, or motor function?:

No ___ Yes ___ If yes, Please list: _____

Applicant Signature: _____ Date Signed: _____

APPLICANT NAME: _____ **PART II** **Submit pages 1 & 2 before Orientation**

TO THE EXAMINING HEALTH PROFESSIONAL: The individual, identified in Part I, has applied for admission to a Nursing Program at Navarro College. Please review the previous page (Part I) which has the student's health history and other information provided by the student. Complete Part II below.

Height: _____ Weight: _____ Pulse + Rate/Rhythm: _____ Resp. _____ Blood Pressure _____

Vision (with correction if applicable): R _____ L _____ Correction necessary? _____

Hearing (with aid if applicable): R _____ L _____ Aid necessary? _____

Sense of smell: _____ Sense of touch: _____

Other: _____

Any assisting patient restrictions, or lifting restrictions, _____

Based on your evaluation, should this individual be able to perform the functional requirements of the Navarro College Nursing Program Student Nurse, i.e. assisting/positioning patients, lifting, assessing: seeing, hearing, sense of smell, and sense of touch

Yes _____ No _____ If no, please explain: _____

Does this individual have routine medications that are likely to impair judgment, alertness, or motor skills? No _____

Yes _____ If yes: please explain - _____

Attach signed documentation for any immunizations given.

Health Professional

Signature:	Address: Phone Number:
Printed Name:	
Date of Exam:	