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: _____

Physical Assessment Form: Continued next page (Part II)

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:
Printed Name:	
Date of Exam:	Phone Number: