

Health Examination Form

Each nursing student must have signed by a licensed M.D., N.P., C.N.M., or P.A.(complete the form below within 30 days prior to the start of the program)

Student name: _____ **Birth Date:** _____

Gender: male _____ female _____ **Height/ Weight** _____ / _____

Vital Signs: B/P _____ / _____ **Pulse** _____ **Respiratory rate** _____ **Temperature** _____

Vision OS: _____ **OD:** _____ **OU:** _____ **Hearing R:** _____ **L:** _____

| System | Function WNL | | Comment |
|-----------------|--------------|----|---------|
| | Yes | No | |
| General | | | |
| HEENT | | | |
| CV | | | |
| Pulmonary | | | |
| GI | | | |
| GU | | | |
| Neurological | | | |
| Integument | | | |
| Musculoskeletal | | | |
| Immune system | | | |
| Endocrine | | | |
| Mental Health | | | |

| Function | Ability to Perform | | |
|---|--------------------|----|---------|
| | Yes | No | Comment |
| Able to work standing, sitting, bending, lifting | | | |
| Able to use all physical senses | | | |
| Able to perform fine motor skills | | | |
| Able to coordinate physical and mental activities to perform tasks or skills safely | | | |
| Able to communicate effectively in English | | | |
| Possess sound mental health | | | |
| Does not have any disability that would interfere with cognitive, | | | |

Provider's Signature: _____

stamp

Print Name: _____

Address: _____