



**Associate Degree in Nursing with Practical Nursing Exit Option  
PHYSICAL AND IMMUNIZATION FORM**

All areas are required to be completed for acceptance as a completed physical for the SRC Nursing program.

**NURSING STUDENT APPLICANT INFORMATION (to be completed by nursing student applicant):**

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Last Name	First Name	Middle Initial
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Home Address (Number and Street)	City/Town	State	Zip Code	Date of Birth
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Home Telephone Number	Alternate Telephone Number
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**IMMUNIZATION INFORMATION (to be completed by the physician):**

**To the examining physician:** Comment on all positive answers and indicate date of disease, immunization, or results of lab tests.

**\*Mumps immunization:** must have been received after 1979 or immunity from disease confirmed by a physician.

**\*Tetanus booster:** required documentation of booster if immunization was not within the last ten years.

**\*Tuberculosis testing:** TB test must be current. A baseline 2-step test is required for all students who have not had a previous 2-step. A one step test is required each year thereafter. A negative chest X-ray and yearly physician documentation of negative physical signs and symptoms of tuberculosis is required for any positive TB skin test.

DISEASE	DATE OF IMMUNIZATION			DATE OF DISEASE	LAB RESULTS/COMMENTS
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
Measles					
*Mumps					
Rubella					
Polio					
*Tetanus-Diphtheria Booster					
*Tuberculosis testing					
Hepatitis B					

**PHYSICAL INFORMATION (to be completed by the physician):**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Corrected Vision: Right 20/\_\_\_\_\_ Left 20/\_\_\_\_\_

<b>Any abnormalities of the following areas?</b>	<b>YES</b>	<b>NO</b>	<b>IF YES, PLEASE EXPLAIN. (include current treatments)</b>
Head, Ears, Nose, or Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Hernia			
Musculoskeletal			
Metabolic/Endocrine			
Neurological			
Psychiatric			
Skin			
Lymph Nodes			

	<b>YES</b>	<b>NO</b>	<b>IF YES, PLEASE EXPLAIN. (Attach additional sheets as necessary)</b>
Is there loss or serious impaired function of any organ or limb?			
Is there any back impairment or lifting restrictions? (need to be able to individually lift a minimum of 50 lbs)			
Do you have any recommendations for any physical or emotional/psychological restrictions?			
Is there any reason the student cannot physically or emotionally/psychologically participate in the nursing program?			

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Last Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_