# nursinglogo

### Department of Nursing

### 23235 N. Co. 22

**Canton, IL 61520**

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**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.**

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

Last Name First Name Middle Initial

Home Address (Number and Street) City/Town State Zip Code Date of Birth

Home Telephone Number Alternate Telephone Number

**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 immunity lab tests. Having disease as a child without proof of immunizations will required titer showing immunity.

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

**\*Tdap 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. Provide date given and date read along with results for both. 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** |
|   | **1st**  | **2nd**  | **3rd**  | 4th |
| Chickenpox |   |   |   |   |  |   |
|  |
| Measles |   |   |   |   |   |   |
| \* Mumps |  |  |  |  |  |  |
| Rubella |   |   |   |   |   |   |
|
| Polio |   |   |   |   |   |   |
|
| DPT |   |   |   |   |   |   |
| Booster Tetanus-Diphtheria Pertussis |   |   |   |   |   |   |
| \*Tuberculosis testing |   |   |   |   |   |   |
|  |  |  |  |  |  |  |
| Hepatitis B |   |   |   |   |   |   |
|

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **IF YES, PLEASE EXPLAIN.****(Attach additional sheets as necessary)** |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Rev’d TS 10/2018***