Department of Nursing
23235 N. Co. 22
Canton, IL 61520
Ph: (309) 649-6227

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):

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 require 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			

QUESTION	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_____